

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13135

CERTIFICATE OF DEATH

13123

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) c. LENGTH OF STAY IN Hagerstown, Md. 3 weeks d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Allegany c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Cumberland d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 225 Maple St.			
3. NAME OF DECEASED (Type or print) DOMINIGO Domenico ALI First Middle Last		4. DATE OF DEATH NOV 11 1961 Month Day Year		9. AGE (In years last birthday) 71 yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH July 26, 1890 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Trackman 10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Caulonia, Italy 12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME Elarca Ali			14. MOTHER'S MAIDEN NAME Catherine Lipari				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes War I (If yes give year or dates of service)		16. SOCIAL SECURITY NO. 705-07-6706		17. INFORMANT Mrs. Marie Ali, Cumberland, Md. Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) GRANULOMA FUNGOIDES 205X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) } DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from 10-20-1961 to 11-11-1961, that (I) last saw the deceased alive on 11-11-1961, and that death occurred at 11:55 M, from the causes and on the date stated above.							
22a. SIGNATURE Antonio U. Pallacrosi M.D.				22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>			
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLACROSI				22d. ADDRESS 1500 Pa. Ave. Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Nov. 14, 1961		23c. NAME OF CEMETERY OR CREMATORY St. Ambrose Cemetery			
23d. LOCATION (City, town or county) Cresaptown, Md.		24. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md. ADDRESS					
25a. REC'D BY REGISTRAR NOV 14 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Finner					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

18115

(P)

TO THE DIRECTOR, BUREAU OF THE ARMY, WASHINGTON, D. C.

FROM THE CHIEF OF THE BUREAU OF THE ARMY, WASHINGTON, D. C.

SUBJECT: [Illegible]

[The remainder of the document contains several paragraphs of text that are extremely faint and illegible due to the quality of the scan. The text appears to be a formal report or memorandum.]

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81
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1
BP
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13136 CERTIFICATE OF DEATH 13124											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) (Rural) Williamsport RFD #2 d. STREET ADDRESS Williamsport Md RFD #2 9. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Michael Todd Ausherman						4. DATE OF DEATH Month Nov. Day 11 Year 19 61					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 10-61		9. AGE (In years last birthday) yrs. 20		IF UNDER 1 YEAR Months 20 Days 20 Hours 20 Min. 20	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Kenneth Ausherman						14. MOTHER'S MAIDEN NAME Sheridan Ann Cooper					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. none		17. INFORMANT Mr. Kenneth Ausherman		Address Williamsport Md RFD #2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congenital Atelectasis 7620 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 20 hrs											
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) 21. I certify that (I) (this hospital) attended the deceased from Nov 10, 1961 to Nov 11, 1961 , that (I) (we) last saw the deceased alive on Nov 11, 1961 , and that death occurred at 11 A.M. from the causes and on the date stated above. 22a. SIGNATURE Philip J. Hirshman 22b. DATE SIGNED 11/12/61 22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman 22d. ADDRESS Hagerstown Maryland 22e. REC'D BY REGISTRAR NOV 14 '61 22f. REGISTRAR'S SIGNATURE Arthur S. Kraus											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 13-61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Stief ADDRESS Williamsport, Md 25a. REC'D BY REGISTRAR NOV 14 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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(M)

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Washington

Washington

Washington

Hagerstown

1 day

(Rural) Williamsport RPD 2

Washington County Hospital

Williamsport 4 RPD 42

Michael

Annexed

Nov. 11

Nov. 10-21

White

None

Maryland

Kenneth A. Auerman

Theresa Ann Cooper

None

T. Kenneth Auerman

Williamsport RPD 42

Nov. 11-21

Hagerstown Maryland

Nov. 11-21 Rest Haven Cemetery Hagerstown MD.

MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13137

13125

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING c. LENGTH OF STAY IN 1b 5 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RESIDENCE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD. d. STREET ADDRESS S. MARTIN e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) BRONSON First BARNETT Middle BARNETT Last		4. DATE OF DEATH NOVEMBER 20 19 61 Month Day Year	
5. SEX MALE 6. COLOR OR RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH MAY 3, 1899 9. AGE (In years last birthday) 62 yrs. 6 Months 17 Days 17 Hours 17 Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) PAINTER 10b. KIND OF BUSINESS OR INDUSTRY HOUSE PAINTER 11. BIRTHPLACE (County & State, or foreign country) WOLF SUMMIT W. VA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EARL BARNETT		14. MOTHER'S MAIDEN NAME GENEVA JARVIS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES WORLD WAR 1		16. SOCIAL SECURITY NO. 234-14-0207 17. INFORMANT MILLARD E. SHANK Address CLEAR SPRING, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Acute Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Healed Gastric Ulcer INTERVAL BETWEEN ONSET AND DEATH Sudden		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Sept 15, 1961 to Nov 20, 1961 ; that (I) (we) last saw the deceased alive on Nov 17, 1961 , and that death occurred at 11/20/61 from the causes and on the date stated above.			
22a. SIGNATURE David R. Brewer M.D.		22b. DATE SIGNED 11/24/61	
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/22/61	
23c. NAME OF CEMETERY OR CREMATORY BLOOMING ROSE CEMETERY		23d. LOCATION (City, town or county) (State) FRIENDSVILLE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Rowland		25a. REC'D BY REGISTRAR NOV 24 '61 DATE	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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1883

CERTIFICATE OF BIRTH

1883

WASHINGTON

WASHINGTON

GEORGE J. BROWN

GEORGE J. BROWN

RESIDENCE

RESIDENCE

GEORGE J. BROWN

GEORGE J. BROWN

WHITE

WHITE

PAINTER

HOUSE PAINTER

PAUL BROWN

PAUL BROWN

AGE

AGE

George J. Brown

George J. Brown

George J. Brown
David R. Brown
George J. Brown

George J. Brown
David R. Brown
George J. Brown

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13138

13126

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY in 1b <u>23 yrs.</u>		f. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>209 High St.</u>				h. STREET ADDRESS <u>1 209 High St.</u>			
3. NAME OF DECEASED (Type or print) <u>Clyde Hartle Barnhart</u>				4. DATE OF DEATH Month <u>November</u> Day <u>19</u> Year <u>1961</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 19, 1886</u>		9. AGE (in years last birthday) <u>75</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sheet Metal</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fairchild Aircraft</u>		11. BIRTHPLACE (County & State, or foreign country) <u>State Line, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Harry W. Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Ada Ann Hesser</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>188-03-9951</u>		17. INFORMANT <u>Mrs. C. H. Barnhart 209 High St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma - Stomach</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Arteriosclerotic Heart Disease</u> (b) <u> </u> (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u> <u>240.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 26, 1961</u> to <u>Nov. 19, 1961</u> , that (I) (we) last saw the deceased alive on <u>Sept. 4, 1961</u> , and that death occurred at <u>10 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Philip J. Hirshman</u>				22b. DATE SIGNED <u>11/22/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Philip J. Hirshman, M.D.</u>	
22d. ADDRESS <u>159 W. Washington St. Hagerstown, Maryland</u>		22e. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/22/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. G. Host</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 21 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

(M)

(I)

123 N. Washington St.
Hawthorne, N.Y.

Philip A. Harrison, H.D.

11/20/61
11/20/61
11/20/61

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

13139

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13127

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>5 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Rural Hagerstown</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>R # 6</u>				1d. STREET ADDRESS <u>R # 6</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Edgar</u> Middle <u>Dale</u> Last <u>Barnhart</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>3</u> Year <u>19 61</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr. 4, 1895</u>		9. AGE (In years last birthday) <u>66</u> yrs.	IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maintenance</u>		11. BIRTHPLACE (State or foreign country) <u>State Line, Penna.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Harry W. Barnhart</u>				14. MOTHER'S MAIDEN NAME <u>Ida Ann Hesser</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-14-6148</u>		17. INFORMANT <u>Mrs. Edythe Moore R # 6 Hagerstown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO (b) <u>Hypertension</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (c) <u>Essential Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>A. W. Ditto, Jr.</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Dr. E. W. Ditto, Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-4-61</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/6/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>				24a. REC'D BY REGISTRAR <u>Wm. C. Hunt</u>		24b. REGISTRAR'S SIGNATURE <u>Orlando S. Kenna</u>		

MEDICAL CERTIFICATION

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13137

(M)

1. Name of deceased		2. Sex		3. Age		4. Date of death	
5. Place of death		6. Cause of death		7. Manner of death		8. Signature of Medical Examiner	
9. Signature of Coroner		10. Signature of Physician		11. Signature of Nurse		12. Signature of Undertaker	
13. Signature of Burial Director		14. Signature of Cemetery		15. Signature of Funeral Home		16. Signature of Mortician	
17. Signature of Embalmer		18. Signature of Transporter		19. Signature of Interment		20. Signature of Burial	
21. Signature of Cremation		22. Signature of Disposition		23. Signature of Release		24. Signature of Return	
25. Signature of Other		26. Signature of Other		27. Signature of Other		28. Signature of Other	
29. Signature of Other		30. Signature of Other		31. Signature of Other		32. Signature of Other	
33. Signature of Other		34. Signature of Other		35. Signature of Other		36. Signature of Other	
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65. Signature of Other		66. Signature of Other		67. Signature of Other		68. Signature of Other	
69. Signature of Other		70. Signature of Other		71. Signature of Other		72. Signature of Other	
73. Signature of Other		74. Signature of Other		75. Signature of Other		76. Signature of Other	
77. Signature of Other		78. Signature of Other		79. Signature of Other		80. Signature of Other	
81. Signature of Other		82. Signature of Other		83. Signature of Other		84. Signature of Other	
85. Signature of Other		86. Signature of Other		87. Signature of Other		88. Signature of Other	
89. Signature of Other		90. Signature of Other		91. Signature of Other		92. Signature of Other	
93. Signature of Other		94. Signature of Other		95. Signature of Other		96. Signature of Other	
97. Signature of Other		98. Signature of Other		99. Signature of Other		100. Signature of Other	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13140

13128

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> Life c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>300 S. Mount Valla Ave.</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>300 S. Mount Valla Ave.</u>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Foster Marcellus Batt Sr.</u>				4. DATE OF DEATH Month Day Year <u>Nov. 2 19 61</u>							
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 2, 1899</u>		9. AGE (In years last birthday) <u>62</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Taxi driver</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Transportation</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Charles Edward Batt</u>						14. MOTHER'S MAIDEN NAME <u>Sara Elizabeth Bowers</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)				16. SOCIAL SECURITY NO. <u>214-09-2236</u>				17. INFORMANT Address <u>Hagerstown, Md.</u> <u>Mrs. Lena J. Batt 300 S. Mount Valla Ave.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hydrostatic Pneumonia</u> DUE TO (b) <u>Hypertensive Cardiovascular Disease</u> DUE TO (c) <u>Cerebro Spinal Luxe</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs.</u> <u>6 yrs.</u> <u>30 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1, 1961</u> , to <u>Nov 2, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 2, 1961</u> , and that death occurred at <u>1:45</u> M., from the causes and on the date stated above.											
22a. SIGNATURE <u>Robert P. Conrad M.D.</u>						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11-3-61</u>			
22c. PHYSICIAN'S NAME (Type) <u>Robert P. Conrad M.D.</u>						22d. ADDRESS <u>137 W. Washington St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>11/5/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>				23d. LOCATION (City, town or county) (State) <u>Hagerstown Maryland</u>	
24 FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u>						ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 7 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician. The law also requires that the death certificate be retained by the hospital or attending physician.

VR A15 (4)
 15M 9/60

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18110

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1

W. C. Miller

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13141

13129

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 1 Day d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Middleburg d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Ruth Middle Sprenkle Last Betts		4. DATE OF DEATH Month Nov. Day 2 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/9/1889
9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min. 72	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) J.C. Penney Co.		10b. KIND OF BUSINESS OR INDUSTRY House Duties	11. BIRTHPLACE (County & State, or foreign country) Waynesboro, Pa.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Fred Frick	
14. MOTHER'S MAIDEN NAME Minnie Sprenkle		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	
16. SOCIAL SECURITY NO. 174-20-8203		17. INFORMANT Mrs. James Andrews, Hagerstown Md., #6	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO arterio Sclerotic + Hypertensive Cardio Vascular Disease Conditions, if any, which gave rise to immediate cause (b) 443X (c) Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 1/2 hrs 5 hrs +	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour e.m. Month, Day, Year 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> et work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (his hospital) attended the deceased from May 58 , 19 61 , to 2 AM , 19 61 , that (I) (we) last saw the deceased alive on 3 AM , 19 61 , and that death occurred at 10:20 P , from the causes and on the date stated above.			
22a. SIGNATURE F.F. Luby		22b. DATE SIGNED 4 Nov 61	
22c. PHYSICIAN'S NAME (Type) F.F. Luby		22d. ADDRESS 230 W Potomac St Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/6/61	
23c. NAME OF CEMETERY OR CREMATORY Green Hill		23d. LOCATION (City, town or county) (State) Waynesboro, Franklin Co., Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Walter J. Lane, Waynesboro Pa.		25a. REC'D BY REGISTRAR NOV 6 61 25b. REGISTRAR'S SIGNATURE Arthur S. Frank	

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Washington

MD.

Washington

Washington County Hospital

1 Day

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61

Female

White

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1/9/1889

25

J.C. Tenney Co.

Horse Dishes

Waynesboro, Pa.

U.S.A.

Fred Black

Minnie Sprinkle

174-20-8003

Mrs. James Andrew, Hagerstown Md., 26

to

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*11/28/18
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[illegible]
[illegible]*

Female

1/9/1889

Green Hill

Waynesboro, Virginia

Nov 6 '87

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13142

CERTIFICATE OF DEATH

13130

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DOWNSVILLE ROAD c. LENGTH OF STAY IN 5 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WARBURN BOARDING HOME				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD. d. STREET ADDRESS NONE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SAMUEL J. BLAIR		4. DATE OF DEATH 11 / 4 / 1961		5. SEX MALE 6. COLOR OR RACE WHITE			
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH 2/29/1886		9. AGE (In years last birthday) 75 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER RETIRED			
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME DOWNEY BLAIR			
14. MOTHER'S MAIDEN NAME ANNA ELIZABETH GWIER		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NONE		16. SOCIAL SECURITY NO. 214-14-6436			
17. INFORMANT MRS RUTH MUNDEY		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: (a) IMMEDIATE CAUSE (a) 420.1 (b) DUE TO Ac. MYOCARDIAL INFARCTION (c) DUE TO IMMEDIATE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) NO							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) 11/4/61		20g. (County) 11/4/61		20h. (State) 11/4/61			
21. I certify that (I) (this hospital) attended the deceased from 11/4/61 to 11/4/61 , that (I) (we) last saw the deceased alive on 11/4/61 , and that death occurred at 11/4/61 M, from the causes and on the date stated above.							
22a. SIGNATURE Ralph F. Young		22b. DATE SIGNED 11/6/61		22c. PHYSICIAN'S NAME (Type) M.D.			
22d. ADDRESS		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/7/1961		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY			
23d. LOCATION (City, town or county) CLEAR SPRING, MD.		23e. (State) CLEAR SPRING, MD.					
24. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Lowland		24a. ADDRESS CLEAR SPRING, MD.		25a. REC'D BY REGISTRAR NOV 9 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas		25c. DATE NOV 9 '61					

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WASHINGTON

STANDARD

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DOVERVILLE ROAD

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WARRING DOVERVILLE ROAD

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13143

CERTIFICATE OF DEATH

13131

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 1 week			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last EDGAR HARRY BLOOM				4. DATE OF DEATH Month Day Year November 17 19 61			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1885		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY D.A. Stickell Co.		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Harry Bloom				14. MOTHER'S MAIDEN NAME Elizabeth Myers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220-16-3854		17. INFORMANT Address Mrs. Edna P. Bloom, 614 Sunset Ave. Hagerstown, Maryland.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Heart Disease 4/16 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Rheumatic Heart Disease (c) Rheumatic fever - inactive PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Epileptiform seizures.							INTERVAL BETWEEN ONSET AND DEATH 12 yrs. 28 yrs.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) (State)	
21. I certify that (I) (his hospital) attended the deceased from Oct. 19, 1960 to Nov. 17, 1961 , that (I) (we) last saw the deceased alive on Nov. 17, 1961 , and that death occurred at 2 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Lloyd A. Hoffner M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/18/61	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffner		22d. ADDRESS 214 N. Potomac st.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 11/19/61	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland.			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Maryland.				25a. REC'D BY REGISTRAR DATE NOV 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

13113

13113

(M)

1

Washington, D.C. 20540

Mr. J. Edgar Hoover

Director, Federal Bureau of Investigation

November 17, 1963

Re: White Paper

1. L. B. Nichols, Jr., Director, FBI

2. L. B. Nichols, Jr., Director, FBI

3. L. B. Nichols, Jr., Director, FBI

4. L. B. Nichols, Jr., Director, FBI

5. L. B. Nichols, Jr., Director, FBI

6. L. B. Nichols, Jr., Director, FBI

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12. L. B. Nichols, Jr., Director, FBI

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																			
13144					13132														
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)														
a. COUNTY		Washington			a. STATE		Maryland												
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Hagerstown			b. COUNTY		Washington												
c. LENGTH OF STAY in 1b		8 years			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		Hagerstown												
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
Western Maryland State Hospital					1905 Greenfield Rd.														
3. NAME OF DECEASED					4. DATE OF DEATH		5. SEX												
(Type or print)		First		Middle		Last		Month		Day		Year							
Emma		Frances		BLOOM		11		20		1961									
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.							
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		September 22, 1880		81 yrs.		Months		Days							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)					10b. KIND OF BUSINESS OR INDUSTRY					11. BIRTHPLACE (County & State, or foreign country)					12. CITIZEN OF WHAT COUNTRY?				
Housewife										Baltimore, Maryland					U.S.A.				
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME														
George W. Mitchell					Virginia Currell														
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)					16. SOCIAL SECURITY NO.					17. INFORMANT					Address				
no										Mrs. Lynn L. Brown,					Hagerstown, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia										5 days									
260X DUE TO										33 years									
Conditions, if any, which gave rise to immediate cause (b) Diabetes mellitus																			
(e), stating the underlying cause last. DUE TO (c)																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
Hypertensive cardiovascular disease, coronary arteriosclerosis																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.)														
20c. TIME OF INJURY					20d. INJURY OCCURRED					20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)					20f. (City or town) (County) (State)				
Hour e.m. p.m.					While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>														
19																			
21. I certify that (I) (this hospital) attended the deceased from Nov. 23, 1960 to Nov. 20, 1961, that (I) (we) last saw the deceased alive on Nov. 20, 1961, and that death occurred at P.M. from the causes and on the date stated above.																			
22a. SIGNATURE										22b. DATE SIGNED									
Young E. Chun M.D.										Nov. 20, 1961									
22c. PHYSICIAN'S NAME (Type)										22d. ADDRESS									
YOUNG E. CHUN										1500 penma. Ave Hagerstown, Md									
23a. BURIAL, CREMATION, REMOVAL (Specify)					23b. DATE THEREOF					23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION (City, town or county) (State)				
Burial					11/22/1961					Baltimore Cemetery					Baltimore Maryland				
24. FUNERAL DIRECTOR'S SIGNATURE										25a. REC'D BY REGISTRAR					25b. REGISTRAR'S SIGNATURE				
Suter - Rouzer Funeral Home Hagerstown, Md.										DA NOV 27 '61					Arthur L. Hanes				

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8 years

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1902 Washington

Washington State Hospital

September 22, 1900

White female

Washington, D.C.

Female

Dr. J. H. Gurnell

George F. Mitchell

Law. John L. Gurnell, Washington, D.C.

no

Washington

Washington

Washington

11/22/1901

Washington

Washington State Hospital, Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13145 CERTIFICATE OF DEATH 13133											
Item 9 Film G301 11/24/61 iwk											
1. PLACE OF DEATH a. COUNTY Washington				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown							
c. LENGTH OF STAY IN 1b 35 Yrs				d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 356 East Franklin St							
2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland				b. COUNTY Washington				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 Hagerstown			
d. STREET ADDRESS 356 East Franklin St				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last MARY ELIZABETH BOWERS				4. DATE OF DEATH Month Day Year November 18 1961							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb 10 1893		9. AGE (In years last birthday) 68 67		10. UNDER 1 YEAR Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Charles E. Springer				14. MOTHER'S MAIDEN NAME No Record			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No				16. SOCIAL SECURITY NO. None				17. INFORMANT George E. Bowers Sr			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Arteriosclerosis (c) antemortem				INTERVAL BETWEEN ONSET AND DEATH instant							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown Md.		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/18/61 , 19 19 , to 11/18/61 , 19 19 , that (I) (we) last saw the deceased alive on 12/20 , 19 1961 , and that death occurred at 7:30 A.M. from the causes and on the date stated above.											
22a. SIGNATURE Robert V. H. Campbell				22b. DATE SIGNED 11/29/61							
22c. PHYSICIAN'S NAME (Type) ROBERT V. H. Campbell				22d. ADDRESS Hagerstown Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/20/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR DATE NOV 21 '61				25b. REGISTRAR'S SIGNATURE Andrew S. Kraus			

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

13146
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13134

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland c. LENGTH OF STAY IN lb life time d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Maryland. 03 d. STREET ADDRESS 218 N Jonathan Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Arnold Darnell Broadus				4. DATE OF DEATH Month 11 Day 28 Year 19 61			
5. SEX Male		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-19-1959	
9. AGE (In years last birthday) 2 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY none		9. AGE (In years last birthday) 2 yrs.	
11. BIRTHPLACE (State or foreign country) Hagerstown, Maryland				12. CITIZEN OF WHAT COUNTRY? USA.			
13. FATHER'S NAME Harris Baker				14. MOTHER'S MAIDEN NAME Bertrice D. Broadus.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) none		16. SOCIAL SECURITY NO. none		17. INFORMANT Bertrice D. Broadus. Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Splendored Hemorrhage DUE TO (b) Cerebral Edema DUE TO (c) Myocardial Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.						INTERVAL BETWEEN ONSET AND DEATH 2 1/2 hours	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Supports & have fallen on floor of home					
20c. TIME OF INJURY Month, Day, Year 11-27-61 Hour 4 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Washington Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE [Signature]				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) [Signature]				M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/30/61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12-3-1961		22c. NAME OF CEMETERY OR CREMATORY Piney Grove Cemetery	
23. FUNERAL DIRECTOR John R Watson Jr. Hagerstown Md				24a. REC'D BY REGISTRAR DEC 5 '61		24b. REGISTRAR'S SIGNATURE [Signature]	

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Harold Baker

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21-12-1913

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Washington County Hospital

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Washington

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Pinney Grove Cemetery

Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>md</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>md</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western md St. Hosp.</u>											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>VICIE ANN BROWN</u> 4. DATE OF DEATH <u>NOV 11 1961</u>											
5. SEX <u>F</u> 6. COLOR OR RACE <u>C</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>10-26-79</u> 9. AGE (In years last birthday) <u>82</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS.: Hours <u>0</u> Min. <u>0</u>											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Sharptown</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>											
13. FATHER'S NAME <u>Bes. Brown</u> 14. MOTHER'S MAIDEN NAME <u>Elizabeth Hubbard</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u> 17. INFORMANT <u>Robert Brown</u> Address <u>Hagerstown</u>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> 420.0 DUE TO (b) <u>CONGESTIVE HEART FAILURE</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Arteriosclerotic heart disease</u> INTERVAL BETWEEN ONSET AND DEATH <u>20 DAYS</u> <u>9 MONTHS</u> <u>unknown</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>PYELITIS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)											
21. I certify that (I) (<u>Hospital</u>) attended the deceased from <u>10-6-</u> 19 <u>61</u> to <u>11-11-</u> 19 <u>61</u> , that (I) (<u>no</u>) last saw the deceased alive on <u>11-11-</u> 19 <u>61</u> , and that death occurred at <u>2 P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Antonio U. Pallacrosi</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> 22b. DATE SIGNED											
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLACROSI</u> 22d. ADDRESS <u>1500 Pa Ave Hagerstown</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11-15-61</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Sharptown Cem</u> 23d. LOCATION (City, town or county) (State) <u>Sharptown md</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>Broder M. West</u> ADDRESS <u>Faledun md</u> 25a. REC'D BY REGISTRAR <u>NOV 17 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>											

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13148

CERTIFICATE OF DEATH

13136

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 10 Days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Martin Manor Nursing Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 320 No Prospect St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) ELIZABETH First FRANCES Middle CARPER Last		4. DATE OF DEATH November 26 Month 19 61 Day Year	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Apr 21 1876
9. AGE (In years last birthday) 85 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (County & State, or foreign country) Winchester Fred Co Va.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME George W. Grubbs		14. MOTHER'S MAIDEN NAME Fannie Newcome	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Harry E. Osborne		Address 320 No Prospect St	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhage from esophageal varices 539.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) pt. hemiplegia due to gen/arteriosclerosis + cerebral arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 30 Min.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 6 , 1961, to Nov 26 , 1961, that (I) (we) last saw the deceased alive on Nov 26 , 1961, and that death occurred at 4:15 PM , from the causes and on the date stated above.			
22a. SIGNATURE Edward W. Ditto III M.D.		22b. DATE SIGNED 11/27/61	
22c. PHYSICIAN'S NAME (Type) Edward W. Ditto III, M. D.		22d. ADDRESS 217 West Washington St.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/29/61	
23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		25a. REC'D BY REGISTRAR NOV 29 '61	
ADDRESS Hagerstown Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13 & 14 Film G302 12/18/61 iwk

13149

CERTIFICATE OF DEATH

Reg. Dist. No. 13137

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brunswick, Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Washington County Hospital</u>		d. STREET ADDRESS <u>114 "K" St.</u> 1035-2	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Joseph Daniels Clark</u>		4. DATE OF DEATH Month Day Year <u>Nov. 15 19 61</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/6/83</u>
9. AGE (In years lost birthday) yrs. <u>78</u>		IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Siler, Virginia</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>John A. Clark</u>		14. MOTHER'S MAIDEN NAME <u>Martha J. Hutzler</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MEDICAL RECORD</u>		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis left middle cerebral artery</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>18 days</u> <u>Sev. yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 4</u> , 19 <u>61</u> , to <u>Nov. 15</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov. 15</u> , 19 <u>61</u> , and that death occurred at <u>4:30 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <u>E. B. Moody</u> M.D.			
PHYSICIAN'S NAME (Type) <u>E. B. Moody, M.D.</u>		<u>145 S. Prospect St., Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-18-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>PARK HEIGHTS</u>		22d. LOCATION (City, town, or county) (State) <u>BRUNSWICK, MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>BRUNSWICK, MD</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 22 '61</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13150

13138

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SAN MAR. RURAL c. LENGTH OF STAY IN lb 6 MONTHS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) HAHRNEY-KEEDY MEMORIAL HOME		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE NEW YORK b. COUNTY DUTCHESS COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WAPPINGERS FALLS d. STREET ADDRESS 69X-3 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANKIE E. CORBIN		4. DATE OF DEATH Month Day Year NOVEMBER 25 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JANUARY 25 1882
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		9b. AGE (In years last birthday) 79 yrs.	9c. IF UNDER 1 YEAR Months Days Hours Min. 10 0
10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (County & State, or foreign country) BROOKLYN N.Y.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME THOMAS JEFFERSON SADDINGTON	
14. MOTHER'S MAIDEN NAME EMILY BRADY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO	
16. SOCIAL SECURITY NO. NO		17. INFORMANT MRS. MARJORIE I. ROSS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intestinal Obstruction DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Paralytic Ileus DUE TO (c) Coronary Thrombosis		INTERVAL BETWEEN ONSET AND DEATH 18 day 8 day 1 yr	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov 1 19 61 to Nov 25 19 61 ; that (I) (we) last saw the deceased alive on Nov 24 19 61 , and that death occurred at 11:00 A.M. from the causes and on the date stated above.			
22a. SIGNATURE W. W. Hecker		22b. DATE SIGNED 11/25/61	
22c. PHYSICIAN'S NAME (Type) W. W. Hecker		22d. ADDRESS Boonsboro, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 28 1961	23c. NAME OF CEMETERY OR CREMATORY WAPPINGER FALLS CEMETERY	23d. LOCATION (City, town or county) (State) WAPPINGER FALLS N.Y.
24. FUNERAL DIRECTOR'S SIGNATURE John H. Best		25a. REC'D BY REGISTRAR Boonsboro MD.	
25b. REGISTRAR'S SIGNATURE Charles S. Hines		DATE NOV 29 '61	

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TESTATE OF DEATH

WASHINGTON

WASHINGTON

RIGHTS OF DEATH

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completed by the funeral director. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13131

CERTIFICATE OF DEATH

13139

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Smithsburg</u> c. LENGTH OF STAY IN 1b <u>—</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PO 2 - Smithsburg, md.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Wash.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Smithsburg</u> d. STREET ADDRESS <u>PO 2 - Smithsburg, md.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>RAYMOND G. CORDELL</u>		4. DATE OF DEATH <u>NOV 13 1961</u>		5. SEX <u>M</u> 6. COLOR OR RACE <u>W</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/30/1898</u>		9. AGE (In years last birthday) <u>63</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>St. Thomas, Pa.</u>			
13. FATHER'S NAME <u>Frank Cordell</u>		14. MOTHER'S MAIDEN NAME <u>M. Elizabeth Holstay</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give year or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Mrs. Hazel Cordell</u> Address <u>PO 2 Smithsburg md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>leucinaematosis</u> <u>157X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>leucinaemia of pancreas</u> (c) <u>leucinaemia of lungs</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>10 mos</u> <u>3 mos</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 10, 1961</u> to <u>Nov 13, 1961</u> , that (I) (we) last saw the deceased alive on <u>Nov 13, 1961</u> and that death occurred at <u>4:45 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>G. G. Kohler</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> <u>11/14/61</u>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>G. A. KOHLER</u>		22d. ADDRESS <u>Smithsburg md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>		23b. DATE THEREOF <u>11/16/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Hill Cem.</u>			
23d. LOCATION (City, town or county) <u>Corrytown, Pa.</u>		(State)		24. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Minnich</u>			
ADDRESS <u>Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>NOV 17 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Charles S. Finner</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13152 CERTIFICATE OF DEATH 13140

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 4 hrs, d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 8313 Hagerstown Road d. STREET ADDRESS 130 Clearview Road e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FONROSE WISNER COSEY		4. DATE OF DEATH November 6 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 19, 1901
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME Daniel Cosey		14. MOTHER'S MAIDEN NAME Catherine Fox	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215-09-7296 A	
17. INFORMANT Mrs. Virginia K. Cosey		Address Rd. Hagerstown, Md. 130 Clearview	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable acute ventricular fibrillation with 420.1 DUE TO cardiac arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Heart Disease (myocardial infarct Nov 1960) DUE TO (c) 1 year PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 year			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 2-15-1952 to 11-6-1961 , that (I) (we) last saw the deceased alive on 11-6-1961 , and that death occurred at 5:30 p.m. from the causes and on the date stated above.			
22a. SIGNATURE John H. Hornbaker		22b. DATE SIGNED 11-7-61	
22c. PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.		22d. ADDRESS 154 W. Washington St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/9/61	
23c. NAME OF CEMETERY OR CREMATORY Edge Hill Cemetery		23d. LOCATION (City, town or county) (State) Charlestown, Virginia.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Maryland		25a. REC'D BY REGISTRAR NOV 10 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kline			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 & 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13153

CERTIFICATE OF DEATH

13141

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 16 days d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Frederick c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Thurmont rural d. STREET ADDRESS RD 1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last HATTIE VIOLA DAYHOFF			4. DATE OF DEATH Month Day Year NOV 10 1961		
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH Aug. 28, 1915		9. AGE (In years last birthday) 46 yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10b. KIND OF BUSINESS OR INDUSTRY Fred. Tailoring		11. BIRTHPLACE (County & State, or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME James Few			14. MOTHER'S MAIDEN NAME Mettie B. Shelton		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-14-1047		17. INFORMANT Address Eugene A. Dayhoff Thurmont, Md. RD 1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA OF CERVIX RECURRENT 171X DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH 1 YEAR
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) LEFT HYDRONEPHROSIS					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that (I) (this hospital) attended the deceased from 10-25-61 to 11-10 , 1961, that (I) (was) last saw the deceased alive on 11-10 , 1961, and that death occurred at 230 M, from the causes and on the date stated above.					
22a. SIGNATURE Antonio U. Palliarosi M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) ANTONIO U. PALLIAROSI				22d. ADDRESS 1500 Pa Ave Hagerstown Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-13-61		23c. NAME OF CEMETERY OR CREMATORY Church of Brethern Cem, Rocky Ridge, Md.	
23d. LOCATION (City, town or county) (State)					
24. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Guager ADDRESS Thurmont, Md.				25a. REC'D BY REGISTRAR NOV 14 '61	
				25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13142
CERTIFICATE OF DEATH

13142

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 17 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) MARTIN MANOR REST HOME		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) X RURAL HAGERSTOWN d. STREET ADDRESS RT. #1 CLEARSPRING e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last ELLICE THROCKMORTON DeFOREST		4. DATE OF DEATH Month Day Year NOVEMBER 3 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/16/1884
9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME MASON THROCKMORTON	
14. MOTHER'S MAIDEN NAME ANNIE HUMPHREY		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO	
16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. ELLICE ENYART	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ventricular Fibrillation DUE TO Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 420.0 DUE TO (b) unknown DUE TO (c) unknown		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from July 19, 1961 to Nov. 03, 1961 that (I) (we) last saw the deceased alive on October 30, 1961 and that death occurred at 7:30 PM from the causes and on the date stated above.			
22a. SIGNATURE Archie Robert Cohen M.D.		22b. DATE SIGNED 11/04/61	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/6/61	
23c. NAME OF CEMETERY OR CREMATORY NATIONAL MEM. PARK CEM.		23d. LOCATION (City, town or county) (State) FALLS CHURCH VIRGINIA	
24 FUNERAL DIRECTOR'S SIGNATURE W. J. H. Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 8 '61	
25b. REGISTRAR'S SIGNATURE Arthur L. Hesse			

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Aortic valve disease
Ventricular fibrillation

None

October 11, 1934
Law 12, 1934

Arthur Robert Cohen, M.D.

Chief, Pathology, M.D.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13155 CERTIFICATE OF DEATH 13143											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>						2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u> d. STREET ADDRESS <u>58 Randolph Ave.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <u>Eliza</u> Middle <u>Pearl</u> Last <u>Dieterich</u>						4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>19 61</u>					
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>September 14, 1896</u> 65 yrs.		9. AGE (In years last birthday)		10. IF UNDER 1 YEAR Months <u>6</u> Days <u>18</u> Hours <u>15</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Williamsport, Md.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>						13. FATHER'S NAME <u>Charles Cottrill</u>					
14. MOTHER'S MAIDEN NAME <u>Molly Shank</u>						15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>					
16. SOCIAL SECURITY NO. <u>214-09-2630</u>						17. INFORMANT <u>Mr. Wm. U. Dieterich</u> Address <u>58 Randolph Ave. Hagerstown, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Adenocarcinoma of Colon, polypoid</u> <u>153.8</u> DUE TO <u>With generalized metastasis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>3 mm x 1</u> (c) <u>3 mm x 1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Interval between onset and death</u>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 26</u> , 19 <u>61</u> to <u>Nov. 27</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov. 27</u> , 19 <u>61</u> , and that death occurred <u>Nov. 27</u> , 19 <u>61</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>L. L. Packer</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/27/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>L. L. Packer M.D.</u>						22d. ADDRESS <u>145 W. Washington St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown</u>		(State) <u>Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> ADDRESS <u>Hagerstown, Md.</u>						25a. REC'D BY REGISTRAR <u>NOV 29 1961</u>		25b. REGISTRAR'S SIGNATURE <u>William G. Shank</u>			

13113

13113



Handwritten notes in cursive script, including the phrase "The first of the year".

Handwritten notes in cursive script, including the phrase "The first of the year".

Handwritten notes in cursive script, including the phrase "The first of the year".

MARYLAND STATE HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13156

CERTIFICATE OF DEATH

13144

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Williamsport c. LENGTH OF STAY IN 1b 6 month d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Williamsport SANITARIUM				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington (RURAL) TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R#3 d. STREET ADDRESS Rural Hagerstown RFD #3			
3. NAME OF DECEASED (Type or print) ELISHA Columbus Dorsey				4. DATE OF DEATH Month Nov Day 23 Year 1961			
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-4-1895	9. AGE (In years last birthday) 65 yrs.	IF UNDER 1 YEAR Months 11 Days 18	IF UNDER 24 HRS. Hours 18 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (County & State, or foreign country) Downsville MD		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD P. Dorsey				14. MOTHER'S MAIDEN NAME SARAH DANNER			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Carl Dorsey 2204 Gay St. Hagerstown Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke (Cerebral Hemorrhage) 33IX DUE TO Conditions, if any, which gave rise to immediate cause (b) Atherosclerosis (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) Previous stroke							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from May 1961 to Nov 22 1961 that (I) (we) last saw the deceased alive on Nov 20 1961 , and that death occurred at 3:30 AM , from the causes and on the date stated above.							
22a. SIGNATURE M.E. Byrkit		M.D.	ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11-23-61	
22c. PHYSICIAN'S NAME (Type) Williamsport		22d. ADDRESS Williamsport					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 26-61	23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City, town or county) Near Tighmanton Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Thomas				25a. REC'D BY REGISTRAR NOV 27 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the attending physician and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

(1)

1915

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William M. ...

6 month

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William M.

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Edward P. ...

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Edward P. ...

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Carl Dorsey 2200 Oak St. ...

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Nov. 20-21 ...

Nov. 21-22 ...

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Washington

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Washington

1 week

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Washington County Hospital

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Bel's U.S. Gov. Creek Agriculture

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U.S.A.

John Thomas Barnshaw

Harvey Oliver

St. James Village

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The Myocardial Infarction

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Nov. 14 - 1981 - 11/14/81

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13158

13146

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Carroll</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Westminster</u> d. STREET ADDRESS <u>18 Milton Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>NEWTON MAURICE ECKARD</u>				4. DATE OF DEATH Month Day Year <u>Nov 27 1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Month Day Year <u>Jan 13 1872</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Califf Lotte keeper</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Carroll Co. Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Jesse Richard</u>				14. MOTHER'S MAIDEN NAME <u>Annie De Moss</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>Mrs Leroy Campbell, Westminster Md</u>				Address <u>18 Milton Ave</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>LOBULAR PNEUMONIA</u> <u>144X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>CARCINOMA OF SOFT PALATE c METASTASIS 4 MONTHS</u> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>2 DAYS</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11-24-1961</u> to <u>11-27-1961</u> , that (I) <u>last</u> saw the deceased alive on <u>11-27-1961</u> , and that death occurred at <u>9:45 AM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Antonio U. Pella Grossi</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>ANTONIO U. PALLACROSSI</u>				22d. ADDRESS <u>1700 Pa AVE HAGERSTOWN MD.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/30/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Kraders Cemetery Rural Westminster Md.</u>		23d. LOCATION (City, town or county) (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>J. E. Smyke Jr., Westminster, Md.</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 30 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

MEDICAL CERTIFICATION

13146

13146

(M)

(1)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

1
13159
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

Hedgesville 13147 Berkeley

1. PLACE OF DEATH a. COUNTY XXXXXXXXXX Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE West Va b. COUNTY XXXXXX Berkeley ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hedgesville W Va 85X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hancock Md Nursing Home Main St		d. STREET ADDRESS Route # 1	
3. NAME OF DECEASED (Type or print) Sarah E Eichelberger		4. DATE OF DEATH 11 23 61	
5. SEX Fem	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1878 2 7
9. AGE (In years last birthday) 83 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Hedgesville W Va	
11. BIRTHPLACE (State or foreign country) U S a		12. CITIZEN OF WHAT COUNTRY? U S a	
13. FATHER'S NAME Richard Wood Berkeley Co		14. MOTHER'S MAIDEN NAME Tene Shriver Berkeley Co	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. no	
17. INFORMANT Mrs. Clayton M Canby		Address Hedgesville W V	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Myocarditis 442X DUE TO Cardiovasc Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) renal disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 7/6 1961 to 11/23 61, that (I) (we) last saw the deceased alive on 11/23 1961, and that death occurred at M, from the causes and on the date stated above.			
22a. SIGNATURE H. H. Shaffer M.D.		22b. DATE SIGNED 11/23 61	
22c. PHYSICIAN'S NAME (Type) H. H. Shaffer M.D.		22d. ADDRESS Hedgesville Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-25-1961	
23c. NAME OF CEMETERY OR CREMATORY Tomahawk Cemetery		23d. LOCATION (City, town, or county) (State) Hedgesville Rt. # 2, W. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Howard K. Brown Martinsburg W. Va.		25a. REC'D BY REGISTRAR NOV 27 '61	
ADDRESS		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

18130

CERTIFICATE OF DEATH

18117

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Handbook

Writing Home

How to

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Gene

Book

Chronic Hypertension
and its
treatment



1/1/1918
1/1/1918

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Handbook

Handbook

Partial 11-1-1918 11-1-1918 11-1-1918

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13160

CERTIFICATE OF DEATH

13148

1. PLACE OF DEATH a. COUNTY <u>Washington</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>30 Yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. STREET ADDRESS <u>1127 Security Rd.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Washington County Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Reno</u> Middle <u>Park</u> Last <u>Eyler</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>25</u> Year <u>19 61</u>					
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1903</u>	9. AGE (In years last birthday) <u>58</u> yrs.	IF UNDER 1 YEAR Months <u></u> Days <u></u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hoist Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cement Mfg.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Frederick Co. Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Park Eyler</u>				14. MOTHER'S MAIDEN NAME <u>Emma Susan Beard</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-10-6853</u>		17. INFORMANT Address <u>Mrs. Reno Eyler 1127 Security Rd. Hagerstown Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute liver failure with Coma</u> <u>581.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Cirrhosis of the liver</u> (a), stating the underlying cause last. } DUE TO (c) <u>Unknown</u>				INTERVAL BETWEEN ONSET AND DEATH <u>48 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 25</u> , 19 <u>61</u> , to <u>Nov. 25</u> , 19 <u>61</u> ; that (I) (we) last saw the deceased alive on <u>Nov. 25</u> , 19 <u>61</u> , and that death occurred <u>2:00 pm</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>L.L. Packer</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/27/61</u>			
22c. PHYSICIAN'S NAME (Type) <u>L.L. Packer M.D.</u>		22d. ADDRESS <u>145 W. Washington St. Hagerstown, Md.</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/28/61</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City, town or county) <u>Hagerstown</u>		(State) <u>Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel</u> <u>Wm. G. Horst</u>		ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 29 '61</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it shall be filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13161

13149

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonesboro		c. LENGTH OF STAY IN b 8 Months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Reeder Nursing Home				d. STREET ADDRESS 609 Salem Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARY ELLEN FEISER				4. DATE OF DEATH Month November Day 28 Year 1961			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 15, 1879		9. AGE (In years last birthday) 82 yrs.	IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.	IF UNDER 24 HRS. Hours 0 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Williamsport, Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME JACOB H. PITTSNOGLE				14. MOTHER'S MAIDEN NAME ANNIE (GOSSARD) PITTSNOGLE			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. ---		17. INFORMANT Hagerstown, Maryland. Mrs. Merle Feiser, Lincolnshire Dr.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism acute DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic Heart Disease DUE TO (c) 4200 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 24 Hours Years -							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from April 11-28, 1961 to Nov 28, 1961 , that (I) (we) last saw the deceased alive on 11-28-1961 , and that death occurred at 3 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Hagerstown				22b. DATE SIGNED 11-28-1961			
22c. PHYSICIAN'S NAME (Type) JOSEPH SECONDARI				22d. ADDRESS BOONESBORO Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 12/1/61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman				25a. REC'D BY REGISTRAR DEC 4 61 DATE 25b. REGISTRAR'S SIGNATURE Arthur S. Hanks			

VR A15 (4)
15M 9/60

(M)

18161

18115

(I)

NAVY KILN 2 1811

Naval Yard

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

Naval Yard

House 1-1

House 1-1

House 1-1

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House 1-1

House 1-1

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House 1-1

House 1-1

House 1-1

House 1-1

House 1-1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13162

CERTIFICATE OF DEATH

15150

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u> <u>24 HOURS</u> c. LENGTH OF STAY IN b. <u>24 HOURS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WASH. CO. HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> <u>WASHINGTON</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>CHESTNUT GROVE RURAL</u> d. STREET ADDRESS <u>KEEDYSVILLE RD. 13.1</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>EVA MARY FITZGERALD</u>		4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>12</u> Year <u>1961</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>NOVEMBER 12 1898</u> <u>62</u> yrs. <u>11</u> Months <u>23</u> Days
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>RIVERSIDE VA.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JORDAN SHOEMAKER</u>		14. MOTHER'S MAIDEN NAME <u>ETTA SHOEMAKER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO.</u>		16. SOCIAL SECURITY NO. <u>NONE</u>	
17. INFORMANT <u>EUSTACE B. FITZGERALD</u>		Address <u>KEEDYSVILLE MD. 13.1</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Hemorrhage</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. } DUE TO (b) <u>Hypertensive Heart Disease</u> (c) <u>7em -</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hours</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10-12-1961</u> to <u>11-5-1961</u> , that (I) (we) last saw the deceased alive on <u>11-5-1961</u> , and that death occurred at <u>6 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Secordari</u> M.D.		22b. DATE SIGNED <u>11-5-1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECORDARI</u>		22d. ADDRESS <u>BOONSBORO MD</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>NOV 8 1961</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MT. CARMEL CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>STEELE TAYLOR VA.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John A. Burt</u>		25a. REC'D BY REGISTRAR <u>NOV 8 '61</u>	
24. ADDRESS <u>BOONSBORO MD</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

MEDICAL CERTIFICATION

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13163

CERTIFICATE OF DEATH

Items 1 & 2 Film G300 11/16/61 iwk

13151

1. PLACE OF DEATH a. COUNTY <i>Machington</i>			2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <i>MD</i> b. COUNTY <i>Carroll</i>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>North Ridge Park, Boonshon</i>			c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <i>Union Bridge</i>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <i>Ut. #2 Fahrney-Keedy Memorial</i>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Carrie</i> Middle <i>Louise</i> Last <i>Barner</i>			4. DATE OF DEATH Month <i>11</i> Day <i>11</i> Year <i>1961</i>			
5. SEX <i>Female</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-20-1877</i>	9. AGE (In years last birthday) <i>84</i> yrs.	IF UNDER 1 YEAR Months <i>84</i> Days <i>11</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Home work</i>			11. BIRTHPLACE (County & State, or foreign country) <i>Carroll MD</i>			
13. FATHER'S NAME <i>Gaspe C. Barner</i>			12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			14. MOTHER'S MAIDEN NAME <i>Hannah Jon Barner</i>			
16. SOCIAL SECURITY NO.			17. INFORMANT <i>Chen Barner, Westminster Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hypertensive cardiac vascular disease</i> DUE TO Conditions, if any, which gave rise to immediate cause (b) <i>443X</i> (e), stating the underlying cause last. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <i>18 months</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		
20f. (City or town)		20g. (County)		20h. (State)		
21. I certify that (I) (this hospital) attended the deceased from <i>Sept 2</i> , 1961, to <i>Nov 10</i> , 1961, that (I) (we) last saw the deceased alive on <i>Nov 10</i> , 1961, and that death occurred <i>11:55 PM</i> , from the causes and on the date stated above.						
22a. SIGNATURE <i>G. W. Heelan</i>			22b. DATE <i>Nov. 11, 1961</i>			
22c. PHYSICIAN'S NAME (Type) <i>G. W. Heelan</i>			22d. ADDRESS <i>Boonshon, Md</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11-13-61</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Pipe Creek</i>		
23d. LOCATION (City, town or county) <i>North Uniontown</i>		23e. (State) <i>MD</i>		23f. (Country)		
24. FUNERAL DIRECTOR'S SIGNATURE <i>Raymond T. Wright</i>			25a. REC'D BY REGISTRAR <i>Nov 14 '61</i>			
25b. REGISTRAR'S SIGNATURE <i>Charles S. Kinner</i>			25c. (Address)			

12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

2000

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The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13164

CERTIFICATE OF DEATH

13152

Item 2 Film G302 12/7/61 iwk

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 6 Hrs		2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland		b. COUNTY Washington		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 / Williamsport / Hagerstown		d. STREET ADDRESS High Street		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) BESSIE VIRGINIA GREEN		4. DATE OF DEATH November 27 1961		5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 27 1879		9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook		10b. KIND OF BUSINESS OR INDUSTRY Restaurant		11. BIRTHPLACE (County & State, or foreign country) Boonsboro Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Charles Souffins		14. MOTHER'S MAIDEN NAME No Record		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No --		16. SOCIAL SECURITY NO. 214-09-9168		17. INFORMANT Catherine Green 325 No Cleveland Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c) Ac. Myo CARDIAL IN FRACTION		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH Immediate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 11/27/61 to 11/27/61 , that (I) (we) last saw the deceased alive on 11/27/61 , and that death occurred 11/27/61 M, from the causes and on the date stated above.		22a. SIGNATURE Dr. Ralph Young		22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) Dr. Ralph Young		22d. ADDRESS Williamsport, Wash. Co. Maryland		22e. REC'D BY REGISTRAR DEC 4 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Kraus		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/61		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City, town or county) (State) Boonsboro Wash Co Md	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		25. DATE DEC 4 '61		25a. REC'D BY REGISTRAR DEC 4 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus		25c. DATE		25d. REGISTRAR'S SIGNATURE		25e. DATE		25f. REGISTRAR'S SIGNATURE		25g. DATE		25h. REGISTRAR'S SIGNATURE			

VR A15 (4)
15M 9/60

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Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

Washington County Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be exactly filled in by the funeral director, page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13165 CERTIFICATE OF DEATH 13153											
Item 9 Film G301 11/24/61 iwk											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 4 Yrs d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Garlock Nursing Home						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1023 View St e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) JACK (NMN) GREENWALD						4. DATE OF DEATH November 19 1961 19					
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov 21 1898		9. AGE (In years last birthday) 62/63 yrs.		IF UNDER 1 YEAR: Months 6 Days 19	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Owner-Operator News Agency				10b. KIND OF BUSINESS OR INDUSTRY McKeesport Allaganey Co				12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME David Greenwald						14. MOTHER'S MAIDEN NAME Anna Friedman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				16. SOCIAL SECURITY NO. W.W.#1 193-28-5176				17. INFORMANT Melvin Greenwald 919 Rolling Road Hagerstown Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 260X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Arteriosclerosis - Generalized DUE TO (c) Diabetes Mellitus INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 8 yrs. 31 yrs.											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (the hospital) attended the deceased from Feb , 19 53 to Nov. 19 , 19 61 , that (I) (we) last saw the deceased alive on Nov. 19 , 19 61 , and that death occurred at 3:30 P.M. from the causes and on the date stated above.											
22a. SIGNATURE Lloyd A. Hoffman M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/20/61			
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman						22d. ADDRESS 214 N. Potomac St. Hagerstown, Md					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF 11/21/61		23c. NAME OF CEMETERY OR CREMATORY Bethel Abraham Cemetery Hagerstown, Maryland				23d. LOCATION (City, town or county) (State) Pa.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.						25a. REC'D BY REGISTRAR NOV 21 '61		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

VR A15 (4)
15M 9/60

18103

18103

(M)

(I)

Washington

Washington

Washington

Washington

George Washington

George Washington

Jack

Jack

(M)

Nov 1 1938

Nov 1 1938

George Washington

George Washington

David Williams

David Williams

Yes

Yes

George Washington

George Washington

Nov 19 1941

X

George Washington

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
Reg. Dist. No. 13154									
1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u> ✓				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>			c. LENGTH OF STAY IN 1b <u>6 + 4 mo.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Greencastle</u> <u>75 X 3</u>				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garlock Memorial Conv. Hospital</u>					d. STREET ADDRESS <u>17 S. Carlisle St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLARA</u> First <u>E.</u> Middle <u>HADE</u> Last					4. DATE OF DEATH <u>Nov</u> <u>27</u> <u>1961</u>				
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/1/1868</u>		9. AGE (In years last birthday) <u>93</u> yrs.	
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Keeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>			11. BIRTHPLACE (State or foreign country) <u>Frederick Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob W. Heatherman</u>					14. MOTHER'S MAIDEN NAME <u>Emeline Gross</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Agnes L. Fury</u> Address <u>412 W. Potomac Hagerstown, Md.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General Arteriosclerosis and Arterio-</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. (b) <u>Sclerotic Heart Disease with</u> <u>20 yrs.</u> DUE TO <u>Senility</u> (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Intertrochanteric Fracture of Right hip (Femur)</u>									
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Crawled over foot of bed and fell to floor</u>						
20c. TIME OF INJURY Month, Day, Year <u>6/14/1961</u> Hour <u>7:20</u> o. m. p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Garlock Hospital</u>		20f. (City or town) <u>Hagerstown</u> (County) <u>Wash</u> (State) <u>Md</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.					CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>					ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
					DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>B.</u>			22b. DATE THEREOF <u>11/30/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) <u>Greencastle Pa.</u> (State)		
23. FUNERAL DIRECTOR'S SIGNATURE <u>A.E. Menich</u> ADDRESS <u>Greencastle, Pa.</u>					24a. REC'D BY REGISTRAR <u>NOV 30 '61</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Finner</u>		

90

2

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

(M)

NAME OF DECEASED _____		SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	
AGE _____		DATE OF BIRTH _____	
PLACE OF BIRTH _____		DATE OF DEATH _____	
OCCUPATION _____		CAUSE OF DEATH _____	
PLACE OF DEATH _____		MANNER OF DEATH _____	
SIGNATURE OF MEDICAL EXAMINER _____		SIGNATURE OF CORONER _____	
CITY _____		COUNTY _____	
STATE _____		YEAR _____	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and many event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
13167					13155					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)					
a. COUNTY Washington					a. STATE Maryland					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					b. COUNTY Washington					
c. LENGTH OF STAY IN 1b 12 Hrs					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wash County Hospital					d. STREET ADDRESS 917 So Potomac st					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last MARY CATHERINE HEIST					Month Day Year Nov 23 1961 19					
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		
Female		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		July 11 1887		74 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Packer		10b. KIND OF BUSINESS OR INDUSTRY Hag Rubber Co		11. BIRTHPLACE (County & State, or foreign country) Hagerstown Wash Co Md.		12. CITIZEN OF WHAT COUNTRY? USA				
13. FATHER'S NAME David S. Fisher					14. MOTHER'S MAIDEN NAME Ann J. Alexander					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 214-09-7734					
17. INFORMANT Julian Saunders					Address 917 Sp Potomac st Hagerstown Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Cardiac Standstill 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Posterior Myocardial Infarction (e), stating the underlying cause last. (c) Arteriosclerotic Heart Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Thrombosis of Middle Cerebral Artery										
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>										
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)										
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)										
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work et work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) did not attended the deceased from 11/21 , 19 61 , to 11/23 , 19 61 , that (I) was last saw the deceased alive on 11/21 , 19 61 , and that death occurred at P.M. from the causes and on the date stated above.										
22a. SIGNATURE <i>John C. Stauffer</i>					22b. DATE SIGNED 11/23/61					
22c. PHYSICIAN'S NAME (Type) John C. Stauffer, M.D.					22d. ADDRESS 145 S. Prospect St. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 11/24/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md			
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman					ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR NOV 24 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanes</i>	

13115

13115



Washington

Washington

Hammerston

12 Hrs

12 Hrs

Hammer County Capital

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12 Hrs

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 7/61

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13168					13156				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		WASHINGTON			a. STATE		MARYLAND		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN			b. COUNTY		WASHINGTON		
c. LENGTH OF STAY IN 1b		10 YRS.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		HAGERSTOWN		
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)		901 WOODLAND WAY			d. STREET ADDRESS		901 WOODLAND WAY		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED					4. DATE OF DEATH				
(Type or print)		First Middle Last			November 23, 1961				
LAUGHTY		DUVALL HOLLYDAY			NOVEMBER 23 19 61				
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
FEMALE		WHITE		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		12/13/1882		78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
HOUSEWIFE		HOME		MARYLAND		U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME					
WILLIAM D. MIDDLEKAUFF				ANNA PIPER					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT			
NO				NONE		MR. JOHN S. HOLLYDAY			
						Address: HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage								Indefinite	
3 31X DUE TO								10 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO									
(b) Hypertensive vascular disease									
(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY		Month, Day, Year		20d. INJURY OCCURRED		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
Hour a.m. p.m.		19		While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>					
21. I certify that (I) (this hospital) attended the deceased from Jan. 5, 1951 to Oct. 30, 1961 that (I) (we) last saw the deceased alive on Oct. 30, 1961, and that death occurred at 10 p.m. to 12 midnight approximate									
22a. SIGNATURE				22b. DATE SIGNED					
B. B. Kneisley, M.D.				11/27/61					
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS					
B. B. Kneisley, M.D.				148 West Washington Street Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
BURIAL		11/27/61		FUNKSTOWN CEM.		FUNKSTOWN MD.			
24 FUNERAL DIRECTOR'S SIGNATURE				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
W. J. Normant, Hagerstown, Md.				NOV 28 '61		William S. Thomas			

13118

13118



WILKINSON

HARRISON

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13169

13157

1. PLACE OF DEATH a. COUNTY ALLEGANY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 3 WEEKS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS Z 93 HENDERSON AVE.	
3. NAME OF DECEASED (Type or print) Campbell Arthur Hook		4. DATE OF DEATH Month Day Year Nov. 28, 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH April 14, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		12. BIRTHPLACE (County & State, or foreign country) W. VA.	
13. FATHER'S NAME J. SAMUEL HOOK		14. MOTHER'S MAIDEN NAME ANNA McCARTY	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) NO		16. SOCIAL SECURITY NO. A 576361	
17. CAUSE OF DEATH [Enter only one cause possible for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) Lobular pneumonia 1912 DUE TO Conditions, if any, which gave rise to immediate cause (b) Carcinoma of face, left (e), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Seven years		18. INTERVAL BETWEEN ONSET AND DEATH one week	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Nov. 8, 1961 , to Nov. 28, 1961 , that (I) (we) last saw the deceased alive on Nov. 28, 1961 , and that death occurred at 5:45 PM , from the causes and on the date stated above.			
22a. SIGNATURE Young E. Chun M.D.		22b. DATE SIGNED Nov. 28, 1961	
22c. PHYSICIAN'S NAME (Type) YOUNG E. CHUN		22d. ADDRESS Western Maryland State Hospital Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF NOV. 30, 1961	23c. NAME OF CEMETERY OR CREMATORY HILLCREST BURIAL PARK	23d. LOCATION (City, town or county) (State) CUMBERLAND, MD.
24. FUNERAL DIRECTOR'S SIGNATURE BYRON KIGHT		25a. REC'D BY REGISTRAR DATE NOV 30 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Krauss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



13123

13123

Griffiths, James, 1862

1862

Griffiths, James, 1862

Nov 2, 1862

Nov 2, 1862

Griffiths, James, 1862

Nov 2, 1862

Griffiths, James, 1862

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13170

13158

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg 5 Yrs c. LENGTH OF STAY IN b d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 225 Chaplin St				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Sharpsburg d. STREET ADDRESS 225 Chaplin st e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) SUSAN CATHERINE HUYETT				4. DATE OF DEATH Nov 1 1961 19 Nov 1 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug 6 1883 78 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Calvin Miner				14. MOTHER'S MAIDEN NAME Katherine L. Harbaugh			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 376-18-9893F.		17. INFORMANT Anwilda Scott 225 Chaplin St Sharpsburg Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422-1 DUE TO Arteriosclerosis Cordis-Vasculorum 2 yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis Cordis-Vasculorum 2 yr. DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1959, 1961, to 1961, that (I) (we) last saw the deceased alive on 8/31/61, and that death occurred at 11/3/61, from the causes and on the date stated above.							
22a. SIGNATURE Walter H. Spealy M.D.				22b. DATE 11/3/61			
22c. PHYSICIAN'S NAME (Type) WALTER H. SPEALY MD.				22d. ADDRESS Sharpsburg, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/4/61		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Wash Co Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.				25a. REC'D BY REGISTRAR NOV 6 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

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Andrew R. Gottman

Nov 1 1982

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 3 and 4 may be retained by the hospital or attending physician.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13171
CERTIFICATE OF DEATH

14518

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO RURAL</u> c. LENGTH OF STAY IN 1b <u>43 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>BOONSBORO MD. R. 2</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE <u>MARYLAND</u> f. COUNTY <u>WASHINGTON</u> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BOONSBORO - RURAL</u> h. STREET ADDRESS <u>BOONSBORO MD. R. 2</u> i. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>															
3. NAME OF DECEASED (Type or print) <u>ANNA VIRGINIA ITNYRE</u>		4. DATE OF DEATH <u>NOVEMBER 30 1961</u>		5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL 11-1880</u>		9. AGE (In years last birthday) <u>81 yrs.</u>		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>19</u>		11. IF UNDER 24 HRS. Hours <u>10</u> Min. <u>00</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>				11. BIRTHPLACE (County & State, or foreign country) <u>MT. LENA WASH. CO. MD.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>JACOB ELI WEDDLE</u>				14. MOTHER'S MAIDEN NAME <u>EMMA JANE HARRISON</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NONE</u>				17. INFORMANT <u>THELMA V. ITNYRE BOONSBORO MD. R. 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease with myocardial infarction</u> <u>420.00</u> DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) <u>factur</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Bilateral thrombosis of popliteal arteries</u>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>W</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>W</u>				20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Jan 1961 to 30 Nov 1961</u>				20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>Jan 1961</u> to <u>30 Nov 1961</u> that (I) (we) last saw the deceased alive on <u>29 Nov 1961</u> and that death occurred at <u>215 P</u> from the causes and on the date stated above.																			
22a. SIGNATURE <u>F F Lusby</u>				22b. DATE SIGNED <u>11/21/61</u>				22c. PHYSICIAN'S NAME (Type) <u>F F Lusby</u>				22d. ADDRESS <u>2301 Potomac St Hyattsville Md</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>DEC 3 1961</u>				23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>				23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. CO. MD.</u>							
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kraus</u>				24b. ADDRESS <u>BOONSBORO MD.</u>				25a. REC'D BY REGISTRAR <u>DEC 13 '61</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

1877

CERTIFICATE OF DEATH

1877

Attest my hand and seal of office this 1st day of January 1877.
J. B. Harrison, M.D.
County of Loudoun, State of Virginia.
I hereby certify that the foregoing is a true and correct copy of the original certificate of death filed in my office on the 1st day of January 1877.
J. B. Harrison, M.D.
County of Loudoun, State of Virginia.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13172

13159

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>BEANSBORO</u> <u>3 DAYS</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>REEDER NURSING HOME</u>				2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>MARYLAND</u> <u>WASHINGTON</u> b. COUNTY c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>MAPLEVILLE ROAD. RURAL</u> d. STREET ADDRESS <u>BOONSBORO MD. R. 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>J. LUTHER ITNYRE</u>		4. DATE OF DEATH <u>NOVEMBER 20 1961</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>JANUARY 16-1877</u>		9. AGE (In years last birthday) <u>84 yrs.</u> IF UNDER 1 YEAR Months <u>10</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FRUIT FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>OWN FARM</u>		11. BIRTHPLACE (County & State, or foreign country) <u>NEAR BOONSBORO WASH. CO. MD. U.S.A.</u>			
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JACOB E. ITNYRE</u>		14. MOTHER'S MAIDEN NAME <u>CATHERINE WILKINS</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>219-36-2515</u>		17. INFORMANT <u>MISS THELMA V. ITNYRE</u> <u>BOONSBORO MD. R. 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease with</u> <u>420.0</u> DUE TO <u>myocardial failure</u> Conditions, if any, which gave rise to immediate cause (b) <u> </u> (e), stating the underlying cause last. DUE TO (c) <u> </u>				INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from <u>1955</u> 19 <u> </u> to <u>20 Nov</u> 1961 , that (I) <u>(see)</u> last saw the deceased alive on <u>20 Nov</u> 1961 , and that death occurred at <u> </u> from the causes and on the date stated above.							
22a. SIGNATURE <u>J. J. Lusby</u>		22b. DATE SIGNED <u> </u>		22c. PHYSICIAN'S NAME (Type) <u>J. J. Lusby</u>			
22d. ADDRESS <u>230 N Potomac St Hagerstown Md</u>		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>NOV. 22. 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>			
23d. LOCATION (City, town or county) <u>BOONSBORO WASH. CO. MD.</u>		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bost</u>		ADDRESS <u>BOONSBORO MD.</u>		25a. REC'D BY REGISTRAR <u>NOV 22 '61</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles L. Thomas</u>							

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STATE OF TEXAS

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13173

13160

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN It Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital			2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS /210 Alexander Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) ROY PRESTON JACOBS			4. DATE OF DEATH Month November Day 16 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 28, 1893		9. AGE (In years last birthday) 68 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Baker		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft		11. BIRTHPLACE (County & State, or foreign country) Tilghmanton, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME Benjamin F. Jacobs		
14. MOTHER'S MAIDEN NAME Lida Wade			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		
16. SOCIAL SECURITY NO. 220-05-6023A			17. INFORMANT Mrs. Cecil Jacobs Address Hagerstown, Maryland		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary edema 443X DUE TO (b) Congestive heart failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Hypertension C-V System PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from June 12, 1953 to Nov. 16, 1961 ; that (I) (we) last saw the deceased alive on Nov. 16, 1961 , and that death occurred 8:00 A.M. from the causes and on the date stated above.					
22a. SIGNATURE L. L. Packer Jr			22b. DATE SIGNED 11/17/61		
22c. PHYSICIAN'S NAME (Type) L. L. Packer Jr			22d. ADDRESS 145 W. Washington St. Hagerstown, Md.		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/18/1961		23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	
23d. LOCATION (City, town or county) Hagerstown		23e. (State) Maryland		23f. REGISTRAR'S SIGNATURE Arthur L. Kraus	
24. FUNERAL DIRECTOR'S SIGNATURE Suter Houzer Funeral Home		ADDRESS Hagerstown, Md.		DATE NOV 20 61	

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Benjamin A. Jacobs

250-2600 Ave. Cecil Avenue, Washington, D.C.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13174

CERTIFICATE OF DEATH

13161

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Williamsport</u> c. LENGTH OF STAY IN 1b <u>1 yr. 5 mo.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Williamsport Sanitarium</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Hagerstown Rural</u> d. STREET ADDRESS <u>1 R # 5</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Benjamin Nathaniel Jamison</u>			4. DATE OF DEATH <u>November 30 1961</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>January 28, 1882</u>		9. AGE (In years last birthday) <u>79 yrs.</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Die Caster</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Pipe organ supplies</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Chesnut Grove, Maryland</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>John Henry Jamison</u>				
14. MOTHER'S MAIDEN NAME <u>Mary Ann Ainsworth</u>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				
16. SOCIAL SECURITY NO. <u>214-09-3467</u>			17. INFORMANT <u>Wm. Jales 636 Mulberry St. Hagerstown, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause pertinent for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of Bladder</u> <u>181.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c)					INTERVAL BETWEEN ONSET AND DEATH <u>1 yr.</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic heart disease</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town)		(County)		(State)			
21. I certify that (1) (this hospital) attended the deceased from <u>June 1955</u> to <u>Nov 30, 1961</u> , that (1) (we) last saw the deceased alive on <u>Nov 1, 1961</u> , and that death occurred at <u>6 A.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Paul Harrison</u>			22b. DATE SIGNED <u>11/30/61</u>		22c. PHYSICIAN'S NAME (Type) <u>Paul Harrison M.D.</u>		
22d. ADDRESS <u>318 N. Potomac St. Hagerstown, Md.</u>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/2/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>			
23d. LOCATION (City, town or county) <u>Hagerstown</u>		(State) <u>Md.</u>					
24 FUNERAL DIRECTOR'S SIGNATURE <u>Rest Haven Funeral Chapel Hagerstown, Md.</u> <u>Wm. G. Horst</u>			25a. REC'D BY REGISTRAR DATE <u>DEC 4 '61</u>				
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13175

CERTIFICATE OF DEATH

13162

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TREGO - RURAL</u> c. LENGTH OF STAY IN <u>40 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KEEDYSVILLE MD. R.I.</u>				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>MARYLAND</u> WASHINGTON b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TREGO - RURAL</u> d. STREET ADDRESS <u>KEEDYSVILLE MD. R.I.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS JAMISON</u>		4. DATE OF DEATH <u>NOVEMBER 1 - 1961</u>		5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>APRIL 23 - 1882</u> 9. AGE (In years last birthday) <u>79</u> yrs. IF UNDER 1 YEAR Months <u>6</u> Days <u>8</u> IF UNDER 24 HRS. Hours <u>30</u> Min. <u>minutes</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED FARMER AND BOO. R.R. EMPLOYEE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>CHESTNUT GROVE WASH. CO. MD. U.S.A.</u> 11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON CO. MD. U.S.A.</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>NO RECORD</u> 14. MOTHER'S MAIDEN NAME <u>NO RECORD</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> 16. SOCIAL SECURITY NO. <u>219-14-8172</u> 17. INFORMANT <u>MRS. DAISY JAMISON</u> Address <u>KEEDYSVILLE MD. R.I.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Acute myocardial infarct</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO <u>Generalized arteriosclerosis</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH</u> <u>many years</u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <u>Boonsboro</u> (County) <u>MD</u> (State)		21. I certify that (I) (this hospital) attended the deceased from <u>June 1 - 1951</u> to <u>Nov 1 - 1961</u> that (I) (we) last saw the deceased alive on <u>10 PM</u> and that death occurred <u>10 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Secondari</u> M.D. 22b. DATE SIGNED <u>11-2-1961</u>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <u>Boonsboro Md</u>			
22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARI</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 23b. DATE THEREOF <u>NOV. 5. 1961</u> 23c. NAME OF CEMETERY OR CREMATORY <u>MT. ZION CEMETERY</u> 23d. LOCATION (City, town or county) <u>LOCUST GROVE WASH. CO. MD.</u> (State)					
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Bart</u> ADDRESS <u>Boonsboro MD</u>		25a. REC'D BY REGISTRAR <u>NOV 8 '61</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>					

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FOR STATE
HEALTH DEPT.

TO COUNTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
Item 7 Film 9302 12/12/61 iwr 14522											
1. PLACE OF DEATH a. COUNTY Washington				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland				b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 15 Days				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural 2 Hancock Md.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital				d. STREET ADDRESS Rural 2 Hancock Md.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Emma Kate Keefer				4. DATE OF DEATH 11. 30 19 61							
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4.10.1867		9. AGE (In years last birthday) 94 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country) Hancock Maryla nd		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Isiac Younker				14. MOTHER'S MAIDEN NAME Katherine Hull							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Ray Grove Rural 2 Hancock Md.		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 904.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Fracture Right Hip DUE TO (c) Hypertensive Cardio Vascular Disease										INTERVAL BETWEEN ONSET AND DEATH 6 days 14 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.) Fell in home.							
20c. TIME OF INJURY Month, Day, Year 11-11-19 61				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Hancock, Washington, Md.		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE [Signature]				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				12-1-61			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12.3.61		22c. NAME OF CEMETERY OR CREMATORY Stone Bridge Brethern		22d. LOCATION (City, town, or country) Rural Hancock Washington Md.		(State)	
23. FUNERAL DIRECTOR Howard J. Elmore Hancock Md.				ADDRESS		24a. REC'D BY REGISTRAR DEC 8 '61		24b. REGISTRAR'S SIGNATURE [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18										
13177 CERTIFICATE OF DEATH										
Reg. Dist. No. 13163										
1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>WASHINGTON</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAGERSTOWN</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 HAGERSTOWN</u>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>WASH. COUNTY HOSPITAL</u>					d. STREET ADDRESS <u>1 603 HAYES AVE.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>KENDALL</u>					4. DATE OF DEATH Month Day Year <u>NOVEMBER 5 1961</u>					
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOVEMBER 5, 1961</u>		9. AGE (In years last birthday) yrs. Months Days Min. <u>0 14</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>GENE EDWARD KENDALL</u>					14. MOTHER'S MAIDEN NAME <u>NANCY LEE HAY</u>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>MOTHER</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atelectasis</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Immaturity</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> INTERVAL BETWEEN ONSET AND DEATH <u>6 14/40 hrs</u>										
MEDICAL CERTIFICATION 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)										
21. I certify that I attended the deceased from <u>11-5</u> , 19 <u>61</u> , to <u>11-5</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>11-5</u> , 19 <u>61</u> , and that death occurred at <u>7:15 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>S J Woodlee</u> M.D. <u>115 King St., Hagerstown, Md 11-6-61</u> PHYSICIAN'S NAME (Type) <u>DR. S. F. WADDILL</u> <u>HAGERSTOWN, MD.</u>										
22a. BURIAL (CREMATION, REMOVAL (Specify))			22b. DATE THEREOF <u>11-9-61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>W. C. H.</u>			22d. LOCATION (City, town, or county) (State) <u>Hagerstown, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>John Schaffer, Wash. Co. Hospital</u> ADDRESS					24a. REC'D BY REGISTRAR DATE <u>NOV 13 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thane</u>			

2081306XVO

CERTIFICATE OF DEATH

18177

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<p>1. NAME OF DECEASED MR. J. W. BROWN</p>		<p>2. SEX Male</p>		<p>3. AGE 45</p>	
<p>4. DATE OF DEATH 1917</p>		<p>5. TIME OF DEATH 10:00 AM</p>		<p>6. PLACE OF DEATH Home</p>	
<p>7. CAUSE OF DEATH Heart Disease</p>		<p>8. DISEASE OR INJURY Coronary Artery Disease</p>		<p>9. MANNER OF DEATH Natural</p>	
<p>10. SIGNATURE OF PHYSICIAN J. D. Smith</p>		<p>11. SIGNATURE OF WITNESS A. B. Jones</p>		<p>12. SIGNATURE OF DECEASED J. W. Brown</p>	
<p>13. SIGNATURE OF REGISTRAR C. D. Green</p>		<p>14. SIGNATURE OF CLERK E. F. White</p>		<p>15. SIGNATURE OF JURY F. G. Black</p>	

1917

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13178

13164

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Boonsboro				c. LENGTH OF STAY IN 1b 39 years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. # 2 Fahrney - Keedy Mem. Home				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
3. NAME OF DECEASED (Type or print) FIRMI				d. STREET ADDRESS 61 Randolph Ave.			
5. SEX Female				4. DATE OF DEATH Month November Day 29 Year 19 61			
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 29, 1884		9. AGE (In years last birthday) 77 yrs. IF UNDER 1 YEAR: Months _____ Days _____ IF UNDER 24 HRS.: Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Belgium		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John B. Lambillotte				14. MOTHER'S MAIDEN NAME Julienne Trefois			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT George Lambillotte, Jr. Hagerstown, Md.				Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 4 20.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH. 6 months
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 1 , 19 61 , to Nov. 20 , 19 61 , that (I) (we) last saw the deceased alive on Nov. 20 , 19 61 , and that death occurred at 10 P.M. , from the causes and on the date stated above.							
22a. SIGNATURE G. W. Heelan				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) G. W. Heelan				22d. ADDRESS Boonsboro Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/24/1961		23c. NAME OF CEMETERY OR CREMATORY R. st Haven Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 27 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Hines							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13179

13165

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 64 YEARS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 672 HIGHLAND WAY e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) JOHN CHARLES LEWIS		4. DATE OF DEATH Month NOV. Day 5 Year 1961		5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG 4 1896		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CONDUCTOR				10b. KIND OF BUSINESS OR INDUSTRY RAILROAD				11. BIRTHPLACE (County & State, or foreign country) JEFFERSON W. VIRGINIA				12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME UNKNOWN				14. MOTHER'S MAIDEN NAME UNKNOWN				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO				16. SOCIAL SECURITY NO. 214-09-6039				17. INFORMANT MRS. OLIVE G LEWIS HAGERSTOWN MARYLAND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Pulmonary Edema 527.2 DUE TO Cor Pulmonale Conditions, if any, which gave rise to immediate cause (b) Partial occlusion and thrombus in right main pulmonary artery (Thrombus 2 mons) (c) 3 1/2 years plus												INTERVAL BETWEEN ONSET AND DEATH 30 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Infarct, spleen and kidney												19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (his) XXXXXX attended the deceased from Oct. 3 1961 to Nov. 4 1961 , that (I) (we) last saw the deceased alive on Nov. 4 1961 , and that death occurred at 5:55 am , from the causes and on the date stated above.																			
22a. SIGNATURE W. T. Layman				M.D. WILLIAM T LAYMAN M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 11-6-61				22b. DATE SIGNED							
22c. PHYSICIAN'S NAME (Type) WILLIAM T LAYMAN				23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE THEREOF 11/7/61				23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEMETERY				23d. LOCATION (City, town or county) (State) HAGERSTOWN MARYLAND			
24. FUNERAL DIRECTOR'S SIGNATURE Superior Funeral Home				ADDRESS HAGERSTOWN MD.				25a. REC'D BY REGISTRAR NOV 8 '61				25b. REGISTRAR'S SIGNATURE Arthur L. Evans							

VR A15 (4)
15M 9/60



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1911

WASHINGTON
HARRINGTON

HARRINGTON
HARRINGTON

WASHINGTON COUNTY HOSPITAL

812 PINEHILL WAY

CHURCH

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AND 1 1896

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REPORT CONDUCTOR

HARRINGTON

HARRINGTON W. VIRGINIA

UNKNOWN

UNKNOWN

211-02-0039

MRS. OLIVE D. HARRINGTON HARRINGTON

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13180
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13166

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Rest Home		d. STREET ADDRESS 25 E. Baltimore St.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Nellie Boyd Linebaugh		4. DATE OF DEATH Month November Day 3 Year 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 3, 1875
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Boyd		14. MOTHER'S MAIDEN NAME Elenora Suter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ----	
17. INFORMANT Charles E. Linebaugh Jr.		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic heart disease 4200 DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		INTERVAL BETWEEN ONSET AND DEATH 5 yrs	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10-30-61 to 11-3-61 , 19____, that (I) (we) last saw the deceased alive on 10-30-61 , 19____, and that death occurred at 6 A M, from the causes and on the date stated above.			
22a. SIGNATURE Paul Harrison		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.		22d. ADDRESS 318 N. Potomac St., Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-6-61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 7 '61	
25b. REGISTRAR'S SIGNATURE Caroline S. Hanna			

1-2-3

M

Washington

January 1st 1900

My dear Mr. [Name]

Very

Yours truly

[Signature]

[Name]

Very truly

[Signature]



[Text]

1-2-3

Very truly

[Signature]

[Text]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Inf. from birth certificate 12/22/61 iwk

CERTIFICATE OF DEATH

Reg. Dist. No. 14529

1. PLACE OF DEATH a. COUNTY Washington County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Penna b. COUNTY Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle 75X-3	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Route #2	
3. NAME OF DECEASED (Type or print) First MIDDLE Last BABY GIRL LOWERY		4. DATE OF DEATH Nov. 18, 1961 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 18, 1961
9. AGE (In years last birthday) yrs.		IF UNDER 1 YEAR Months Days Hours Min. 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles F. Lowery		14. MOTHER'S MAIDEN NAME Frances Lee Wolford	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT Medical Record		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Immunity Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 35 min.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11-18-61, 19, to 11-18-61, 19, that I last saw the deceased alive on 11-18-61, 19, and that death occurred at 4:55 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Howard N. Weeks, M.D. 136 N. Potomac St. 12/15/61 PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF 11-19-61	
22c. NAME OF CEMETERY OR CREMATORY Wash. Co. Hospital Lab.		22d. LOCATION (City, town, or county) (State) Hagerstown, Wash. Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE John A. Schaffer, Adm. Wash. Co. Hospital		24a. REC'D BY REGISTRAR DATE DEC 22 '61	
24b. REGISTRAR'S SIGNATURE			

2081253XVO

CERTIFICATE OF DEATH

12181

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
PLACE OF BIRTH [Illegible]		DATE OF BIRTH [Illegible]		TIME OF BIRTH [Illegible]	
PLACE OF DEATH [Illegible]		DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF INTERMENT [Illegible]	
SIGNATURE OF PHYSICIAN [Illegible]		SIGNATURE OF REGISTRAR [Illegible]		SIGNATURE OF WITNESS [Illegible]	
CERTIFICATE OF DEATH [Illegible]		CERTIFICATE OF DEATH [Illegible]		CERTIFICATE OF DEATH [Illegible]	

VR A15 (4)
15M 7/61

13167

1. PLACE OF BIRTH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) ROUTE 1		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) CLEAR SPRING, MD.	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RESIDENCE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		d. STREET ADDRESS NONE	
3. NAME OF DECEASED (Type or print) SUSAN LOUISE MASON		First Middle Last		4. DATE OF DEATH 11 28 19 61	
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3/1/61		9. AGE (In years last birthday) 8 27		10. IF UNDER 1 YEAR Months Days 8 27	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JAMES MASON		14. MOTHER'S MAIDEN NAME CATHERINE MILLS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war/dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS CATHERINE MILLS PERKINS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Vomitus 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH Immediate		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) 11/28/61		20g. (County) 11/28/61		20h. (State) 11/28/61	
21. I certify that (I) (this hospital) attended the deceased from 11/28/61 to 11/28/61 , that (I) (we) last saw the deceased alive on 11/28/61 , and that death occurred at 11/28/61 M, from the causes and on the date stated above					
22a. SIGNATURE Ralph T. Young		22b. DATE SIGNED 11/28/61		22c. PHYSICIAN'S NAME (Type) Ralph T. Young	
22d. ADDRESS Maryland R. Pauland		22e. REC'D BY REGISTRAR DEC 1 '61		22f. REGISTRAR'S SIGNATURE Arthur S. Francis	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/30/61		23c. NAME OF CEMETERY OR CREMATORY CLEAR SPRING MENNONITE	
23d. LOCATION (City, town or county) CLEAR SPRING, MD.		23e. (State) MD.			

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Aspiration No. 1 + 2

11/2/01 11/2/01 11/2/01 11/2/01 11/2/01

11/2/01 11/2/01

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, fill in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTHDIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13183
CERTIFICATE OF DEATH

13168

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Homewood Church Home		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown d. STREET ADDRESS 1 457 N. Potomac Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GARRIE Middle GOOD Last MC CARDELL		4. DATE OF DEATH Month November Day 24 Year 19 61	
5. SEX Female		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 25, 1871	
9. AGE (In years last birthday) 90 yrs.		IF UNDER 1 YEAR Months 03 Days 03	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel M. Good		14. MOTHER'S MAIDEN NAME Mary E. Seibert	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service)		16. SOCIAL SECURITY NO. none	
17. INFORMANT Mrs. Fred Reynolds		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiovascular Collapse 422.1 DUE TO Arteriosclerosis - gen. Conditions, if any, which gave rise to immediate cause (b) min (e), stating the underlying cause last. (c) yr. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Thyroid adenoma.			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 03 p.m. 03		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 61 , 19 61 , to 11/24 , 19 61 , that (I) (was) last saw the deceased alive on Oct 61 , 19 61 , and that death occurred at 11/24 , 19 61 , from the causes and on the date stated above.			
22a. SIGNATURE Louis G. Graff		22b. DATE SIGNED 11/24/61	
22c. PHYSICIAN'S NAME (Type) Louis G. GRAFF		22d. ADDRESS 111 E. Antietam	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/26/1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home		25a. REC'D BY REGISTRAR NOV 29 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

18188

RECORD OF DEATH

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13184

13169

1. PLACE OF DEATH e. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>19 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		d. STREET ADDRESS <u>70 E. Irvin Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Lutie Kendall McGlaughlin</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1961</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept. 14, 1894</u>	
9. AGE (In years last birthday) <u>67 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hous wife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u> </u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington Co. Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Abraham Kendall</u>				14. MOTHER'S MAIDEN NAME <u>Ida Toms</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u> </u>			
17. INFORMANT <u>Mrs. Harold C. Trovinger</u>				Address <u>Hagerstown, Md. 70 E. Irvin Ave.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General carcinomatosis</u> 153.0 DUE TO (b) <u>Carcinoma of the cecum and ascending colon</u> 2 1/2 yr. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Indefinite</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from <u>May 19 8:25 A.M. 1961</u> to <u>Nov. 27, 1961</u> that (1) (we) last saw the deceased alive on <u>Nov. 26, 1961</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>B. B. Kneisley</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/27/61</u>	
22c. PHYSICIAN'S NAME (Type) <u>B. B. Kneisley, M.D.</u>				22d. ADDRESS <u>148 West Washington Street Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/29/61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven</u>		23d. LOCATION (City, town or county) (State) <u>Hagerstown, Washington Co., Md.</u>	
24a. FUNERAL DIRECTOR'S SIGNATURE <u>Walter G. Hue</u>				ADDRESS <u>Waynesboro, Pa.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 30 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles L. Hume</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

M

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1818

Washington

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Washington

19 days

Washington

Washington County Hospital

10 E. 12th Ave.

Initial

Medical

Medical

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Female

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Sup. 1A, 1818

1818

Howe

Washington Co. 1818

Alphabetical

1818

No

Mr. Harold G. Provender to E. 12th Ave.

Washington County Hospital

Department of the county and recording office 1818

Nov. 28

Nov. 28

1818

E. B. Hulseley, L.D.

1818

1818

1818

Washington Co. 1818

Washington Co. 1818

CERTIFICATE OF DEATH

13185

13170

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John William Middlekauff		4. DATE OF DEATH Month November Day 18 Year 19 61	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 1, 1877	
9. AGE (In years last birthday) 84		10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chief Clerk		12. KIND OF BUSINESS OR INDUSTRY Railroad	
13. FATHER'S NAME John H. Middlekauff		14. MOTHER'S MAIDEN NAME Sarah E. Rouskulp	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Anna Middlekauff		Address Hagerstown, md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 180X DUE TO Thyroid left kidney - grand metastases Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) General Arteriosclerosis DUE TO Pneumonia (c) 1961		INTERVAL BETWEEN ONSET AND DEATH 3 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 10/1/61 to 11/18/61 , that (I) (we) last saw the deceased alive on 11-18-61 , and that death occurred 11-18-61 M, from the causes and on the date stated above.			
22a. SIGNATURE A. W. Dethlefsen		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Dethlefsen		22d. ADDRESS Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-21-61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25. REC'D BY REGISTRAR Nov 22 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
13186											
13171											
1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN lb 1 week d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington Co. Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1321 South Mulberry St. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) MARY LOUISE MORT						4. DATE OF DEATH November 3, 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH January 19, 1890		9. AGE (In years last birthday) 71 yrs.		10. IF UNDER 1 YEAR Months 71 Days 71	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waitress				10b. KIND OF BUSINESS OR INDUSTRY Wash. Co. Hospital				11. BIRTHPLACE (County & State, or foreign country) Leitersburg, Wash. Co. Md.		12. CITIZEN OF WHAT COUNTRY? USA.	
13. FATHER'S NAME William Mort						14. MOTHER'S MAIDEN NAME Malinda Dentler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No						16. SOCIAL SECURITY NO. 217-28-7355		17. INFORMANT Miss Emma K. Mort, 321 S. Mulberry St.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.0 DUE TO (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) Indefinite PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20 min.											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year 19 Hour a.m. 19 p.m. 19											
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from July 27, 1961 to Nov. 3, 1961 , that (I) (we) last saw the deceased alive on Nov. 3, 1961 , and that death occurred at 4:15 M, from the causes and on the date stated above.											
22a. SIGNATURE B. B. Kneisley M.D. 11/6/61											
22b. DATE SIGNED 11/6/61											
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.											
22d. ADDRESS 148 West Washington Street Hagerstown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 11/6/61											
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery											
23d. LOCATION (City, town or county) (State) Hagerstown, Maryland											
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Maryland.											
25a. REC'D BY REGISTRAR NOV 10 '61											
25b. REGISTRAR'S SIGNATURE John S. Pratt											

VR A15 (4)
15M 9/60

13444

Washington

Registrar

1931

Washington Co. Hospital

MARY LOUISE ROSE

Female White

January 18, 1930

Address

Wm. Co. Hospital, Baltimore, Md., U.S.A.

William Rose

417-22-7386

Washington Co. Hospital, Baltimore, Md., U.S.A.

Handwritten signature

Butler 12/15/31

Rose Hill Cemetery

Registrar, Maryland

Andrew K. Gorman, Registrar, Maryland

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13187

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 13172

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>Life</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>03 Hagerstown</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington County Hospital D.O.A.</u>				d. STREET ADDRESS <u>11 West Baltimore St.</u>			
3. NAME OF DECEASED (Type or print) First <u>George</u> Middle <u>Mason</u> Last <u>Mose</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>19 61</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 10, 1942</u>		9. AGE (In years last birthday) <u>19 yrs.</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Deliveryman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Meat Products</u>		11. BIRTHPLACE (State or foreign country) <u>Hagerstown, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Carl J. Mose Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Janice Virginia Artz</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>218-38-1584</u>		17. INFORMANT Address <u>Carl J. Mose Sr. 11 W. Baltimore St. Hagerstown, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Of Skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Crushed Chest Right Side</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Car possibly skidded into path of on coming car.</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8:30</u> p. m. <u>11-23-</u> 19 <u>61</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>R#34, 3 Mi. South of Sharpsburg, Washington, Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Dr. E. W. Ditto, Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <u>11-24-61</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/26/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Hagerstown Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wm. C. Horst</u>				24a. REC'D BY REGISTRAR <u>NOV 28 61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Funes</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1918

(M)

<p>1. Name of deceased: _____</p>		<p>2. Sex: _____</p>		<p>3. Age: _____</p>	
<p>4. Date of death: _____</p>		<p>5. Place of death: _____</p>		<p>6. Cause of death: _____</p>	
<p>7. Medical history: _____</p>		<p>8. Post-mortem examination: _____</p>		<p>9. Signature of medical examiner: _____</p>	
<p>10. Signature of attending physician: _____</p>		<p>11. Signature of coroner: _____</p>		<p>12. Signature of registrar: _____</p>	

1918

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13188

CERTIFICATE OF DEATH

13173

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Maryland State Hospital				d. STREET ADDRESS 649 North Mulberry St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Carrie Middle VENORA Last myrtle				4. DATE OF DEATH Month November Day 27 Year 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 29, 1878	
9. AGE (In years last birthday) 83 yrs.		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (County & State, or foreign country) Shenandoah, Page Co. Va.		12. CITIZEN OF WHAT COUNTRY? USA.		14. MOTHER'S MAIDEN NAME Susan Gentry			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mattie L. Entler, 649 N. Mulberry St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Lobular pneumonia, bilateral 331X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) cerebro-vascular accident DUE TO (c) general arteriosclerosis				INTERVAL BETWEEN ONSET AND DEATH 3 days 4 days unknown			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) (1) Hypertension (2) Old cerebrovascular accident				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Shenandoah, Page Co. Va.		20g. (County) Page Co. Va.		20h. (State) Virginia	
21. I certify that (1) (his hospital) attended the deceased from Nov. 16 , 19 61 , to Nov. 27 , 19 61 , that (1) (we) last saw the deceased alive on Nov. 27 , 19 61 , and that death occurred at 3:30 PM , from the causes and on the date stated above.				22a. SIGNATURE Victor L. Ramos, M.D.			
22b. DATE SIGNED Nov. 27, 1961		22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS Western Maryland State Hospital Hagerstown, Maryland		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/30/61		23c. NAME OF CEMETERY OR CREMATORY E.U.B. Cemetery		23d. LOCATION (City, town or county) Shenandoah, Page Co. Va.	
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown, Maryland.				25a. REC'D BY REGISTRAR NOV 29 1961		25b. REGISTRAR'S SIGNATURE Arthur S. Kenna	

MEDICAL CERTIFICATION

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13189

13174

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN lb 60 YRS. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 328 S. POTOMAC ST.				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 1328 S. POTOMAC ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LILLIE MAY NEIKIRK		4. DATE OF DEATH Month NOVEMBER Day 18 Year 1961					
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 5/30/1880	9. AGE (In years last birthday) 81 yrs.	IF UNDER 1 YEAR Months 81 Days 18 Hours 19 Min. 61		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME WILLIAM HENRY ROHRER		14. MOTHER'S MAIDEN NAME MARY E. PUNK		Address HAGERSTOWN MD.			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MISS MARY GROUND			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arterio Sclerotic Heart Disease 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Pneumonia (a), stating the underlying cause last. DUE TO (c) Senility PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 10 yrs 7 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21. I certify that (I) (this hospital) attended the deceased from 7-1-61 to 11-18-61 , 19 61 , that (I) (we) last saw the deceased alive on 11-16-61 , and that death occurred at 3:30 M. from the causes and on the date stated above.							
22a. SIGNATURE A. E. W. Fitts		22b. DATE SIGNED 11/19/61		22c. PHYSICIAN'S NAME (Type) A. E. W. Fitts			
22d. ADDRESS Hagerstown Md		22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/20/61		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			
23d. LOCATION (City, town or county) HAGERSTOWN MD.		(State)					
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment		ADDRESS Hagerstown Md.		25a. REC'D BY REGISTRAR NOV 21 '61			
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus							

13181

13181

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18130



18130

Washington

Maryland

Washington

Washington

to date

General Washington

15 N. Randall Ave.

Station Honor Post Home

November 22, 1913

General Washington

Jan. 21, 1886

General Washington

Volunteer Co. N. Y.

General Washington

General Washington

General Washington

General Washington

General Washington

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General Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13191

13176

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN b 5 days d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington Co. Hospital				2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 8 Glenside Ave e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																							
3. NAME OF DECEASED (Type or print) ALBERT L. PALMER		4. DATE OF DEATH November 17 1961		5. SEX male		6. COLOR OR RACE white		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 1, 1891		9. AGE (In years last birthday) 70		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (County & State, or foreign country) Frederick Co. Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.									
13. FATHER'S NAME Elmer Palmer				14. MOTHER'S MAIDEN NAME Sarah Jane Moser				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 214-09-5764				17. INFORMANT Mrs. Nannie Palmer, 8 Glenside Ave.				Address Hagerstown, Md.							
18. CAUSE OF DEATH [Enter only one cause, but one for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 332X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis (General) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS Myasthenia Gravis				INTERVAL BETWEEN ONSET AND DEATH 6 Days 10 yrs.				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from Nov 12 1961 to Nov 17 1961 , that (I) (we) last saw the deceased alive on Nov 17 1961 , and that death occurred at 10 PM , from the causes and on the date stated above.																22a. SIGNATURE JN Beachley M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				22b. DATE SIGNED Nov 18 1961			
22c. PHYSICIAN'S NAME (Type) JN Beachley				22d. ADDRESS Hagerstown, Md.																							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE THEREOF Nov. 20, 1961				23c. NAME OF CEMETERY OR CREMATORY United Brethren				23d. LOCATION (City, town or county) (State) Myersville, Fred. Co. Md.															
24. FUNERAL DIRECTOR'S SIGNATURE Paul F. Bittle				ADDRESS Myersville, Md.				25a. REC'D BY REGISTRAR NOV 21 '61				25b. REGISTRAR'S SIGNATURE Arthur S. Evans															

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Hagerstown

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Hagerstown

Washington Co. Hospital

8 Glenaida Ave

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November 17

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male

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Jan. 1, 1891

TO

Shomaker

Hagerstown shoe Co.

Frederick Co. Md. U.S.A.

Elmer Palmer

Sarah Jane Moore

no

214-02-5704 Mrs. Hattie Palmer, 8 Glenaida Ave.
Hagerstown, Md.

*George H. Palmer
Hagerstown, Md.*

*George H. Palmer
Hagerstown, Md.*

*George H. Palmer
Hagerstown, Md.*

*George H. Palmer
Hagerstown, Md.*

*George H. Palmer
Hagerstown, Md.*

Final Nov. 20, 1961 United Brotherhood

Myersville, Md.

Myersville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
M
DR. SHEALY
1
MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13192

CERTIFICATE OF DEATH

14541

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 4 DAYS d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) WASH. CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS X e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) SOPHIA T. POFFENBERGER		4. DATE OF DEATH Month Day Year NOVEMBER 30 1961	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH FEBRUARY 11 1885	
9. AGE (In years last birthday) 76 yrs.		10. MONTHS 7	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON CO. MD. U.S.A.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME CHRISTIAN M. POFFENBERGER		14. MOTHER'S MAIDEN NAME MARY ANN LINE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 213-09-8526	
17. INFORMANT J. EVANS POFFENBERGER		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic cardio-vascular disease (c), stating the underlying cause last. 10 Yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Lobar pneumonia	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from 1957 , 19 11/29/61 , to 11/30/61 , 19 11/30/61 , that (I) (we) last saw the deceased alive on 11/29/61 , and that death occurred at M. , from the causes and on the date stated above.		22. SIGNATURE Walter H. Shealy M.D. 22c. PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.	
22a. ATTENDING PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED 12/2/61	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF DEC. 3, 1961	
23c. NAME OF CEMETERY OR CREMATORY BAKERSVILLE CEMETERY		23d. LOCATION (City, town or county) (State) BAKERSVILLE WASH. CO. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. East		25a. REC'D BY REGISTRAR DEC 13 '61	
25b. REGISTRAR'S SIGNATURE Beonsboro MD.		25c. REGISTRAR'S SIGNATURE Arthur S. Kraus	

18102

CERTIFICATE OF DEATH

1151

WASHINGTON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 10 minutes d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital		2. USUAL RESIDENCE (Where deceased lived, if not usual residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport RFD #2 d. STREET ADDRESS Pinesburg Williamsport RFD2 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) William Richardson Potts Sr.		4. DATE OF DEATH Month Nov. Day 16 Year 19 61	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 16 1899
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Western Md. State Hospital	9. AGE (In years last birthday) 62 yrs. IF UNDER 1 YEAR: Months 4 Days 0 IF UNDER 24 HRS.: Hours Min.
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A	
13. FATHER'S NAME George W. Potts		14. MOTHER'S MAIDEN NAME Elizabeth R Harsh	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 215 09 7358	
17. INFORMANT William R. Potts		736 Robinwood Drive Hagerstown Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Ac Myocardial Infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) IMMEDIATE (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 11/16/61 to 11/16/61 , that (I) (we) last saw the deceased alive on 11/16/61 , and that death occurred at 11/16/61 M, from the causes and on the date stated above.			
22a. SIGNATURE Ralph F. Young		22b. DATE SIGNED 11/17/61	
22c. PHYSICIAN'S NAME (Type) Ralph F. Young		22d. ADDRESS Williamsport Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Nov. 20-61	23c. NAME OF CEMETERY OR CREMATORY St. Pauls Cemetery	23d. LOCATION (City, town or county) (State) Near Clearspring Md.
24. FUNERAL DIRECTOR'S SIGNATURE William R. Potts, Williamsport, Md.		25a. REC'D BY REGISTRAR NOV 20 '61 DATE	
		25b. REGISTRAR'S SIGNATURE Arthur S. Hume	

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Washington

Marston

Washington County Hospital

William

Richardson

Porter St.

Nov.

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Wife

White

July 16 1899

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U.S.A.

Virginia

Western D. State Capital

Attendant

George W. Porter

Elizabeth R. Porter

100 Bonwood Drive

Porter, Virginia

215 22 7358 William

For inspection of the court

11/1/01

11/1/01

11/1/01

11/1/01

William Porter

Ralph J. Jones

Nov. 20-61 St. Paul Cemetery West Chester, Pa.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
13194											
13178											
1. PLACE OF DEATH e. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b Life d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Washington County Hospital						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 2023 Virginia Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Elizabeth Ann Rhoades						4. DATE OF DEATH November 27 1961					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH May 8, 1927		9. AGE (In years last birthday) 34 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Hagerstown, Md.				12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Crist W. Fuller						14. MOTHER'S MAIDEN NAME Grace V. Seibert					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) ----				16. SOCIAL SECURITY NO. ----		17. INFORMANT Charles Fuller Hagerstown, Md.				Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia Bilateral 526X DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) HT. Ventricular Cordial Hypertrophy DUE TO (c) Pulmonary Congestion + Edema										INTERVAL BETWEEN ONSET AND DEATH 12 yrs 3 mo 2 wks	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 1 - 66 to Oct 27, 1961 , that (I) (we) last saw the deceased alive on Oct 26, 1961 , and that death occurred at 4 PM , from the causes and on the date stated above.											
22a. SIGNATURE [Signature]						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) Dr. E. W. J. [Signature]						22d. ADDRESS Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-30-61		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery				23d. LOCATION (City, town or county) Hagerstown, Md. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DEC 1 '61		25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]			

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Washington

Washington County Hospital

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Maryland

Washington

2023 Virginia Ave.

Elizabeth

Ann

Shoban

November

Female White

May 2, 1927

Don Home

Home Life

Harperstown, Md.

Chief W. Miller

Gracie V. Solberg

Charles Miller Harperstown, Md.

Chief

12-30-01

Head Master Cemetery

Harperstown, Md.

Scott I. Winnick - Don Harperstown, Md.

TO DEPT. OF HEALTH: This certificate should be executed within 24 hours after death. If a delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13195 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13179

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hancock c. LENGTH OF STAY IN 1b 50 Yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Home				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hancock d. STREET ADDRESS W. Main St. Hancock Md. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) Iva Belle Rhodes		4. DATE OF DEATH 11 11 19 61		5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3.28.1880		9. AGE (In years last birthday) 81 yrs.		10. IF UNDER 24 HRS. Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housewife				11. BIRTHPLACE (State or foreign country) Somerset County Penna.				12. CITIZEN OF WHAT COUNTRY? U.S.A.											
13. FATHER'S NAME Andrew Fleisschhauer				14. MOTHER'S MAIDEN NAME Mary E Griffith				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)				16. SOCIAL SECURITY NO. None				17. INFORMANT Mrs Bertha Heller Hancock Md. Address							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO General Chronic Pelvic Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Senility DUE TO Malignant (c) Malnutrition												INTERVAL BETWEEN ONSET AND DEATH 10 yrs											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Confined to wheel chair for years												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)																	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																							
ACTUAL SIGNATURE A. E. White M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 11/11/61							
EXAMINER'S NAME (Type) A. E. White				Address (Street, city, town, or county)				22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 11.14.61				22c. NAME OF CEMETERY OR CREMATORY Hopewell Methodist				22d. LOCATION (City, town, or country) (State) Hopewell Somerset Penna.			
23. FUNERAL DIRECTOR Howard J. Stone				ADDRESS Hancock Md.				24a. REC'D BY REGISTRAR NOV 14 '61				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus											

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General County Court, D.C.

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General County Court, D.C.

General County Court, D.C.

General County Court, D.C.

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

13198
MAYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
13180

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived; If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>	
c. LENGTH OF STAY IN 1b <u>1 month</u>		d. STREET ADDRESS <u>68 Lincoln Apt</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Western Maryland State Hosp</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Howard Henry ROBINSON</u>		4. DATE OF DEATH Month Day Year <u>11 10 1961</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-9-1892</u>
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Contractors Helper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Fred Brick wks</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Henry Robinson</u>		14. MOTHER'S MAIDEN NAME <u>Luvenia Robinson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>220-10-5534</u>	
17. INFORMANT <u>Lucy Doozie Robinson</u>		Address <u>Frederick 68 Lincoln</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 90400 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Fracture Femur Rt.</u> DUE TO (c) <u>3 mo</u>		INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. <u>Chronic of Lung + Asthma</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>Fell on floor</u>	
20c. TIME OF INJURY Month, Day, Year Hour e.m. <u>Nov 15 1961</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) (County) (State) <u>Frederick Frederick Md</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural Causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>[Signature]</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. E. W. Little</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-13-61</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Fairview</u>		22d. LOCATION (City, town, or country) (State) <u>Frederick Maryland</u>	
23. FUNERAL DIRECTOR <u>C.E. Hicks, lll</u>		ADDRESS <u>Frederick, Md</u>	
24a. REC'D BY REGISTRAR <u>NOV 14 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Huns</u>	

DATE SIGNED
11/10/61

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13197

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13181

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 60 years	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 83 Hagerstown		d. STREET ADDRESS 345 N. Potomac St.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Addie Simmons Roe		4. DATE OF DEATH Month Day Year November 14 19 61	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1881
9. AGE (In years last birthday) yrs. 80		IF UNDER 1 YEAR Months Days Hours Min. 80	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attendant		10b. KIND OF BUSINESS OR INDUSTRY Day Nursery	
11. BIRTHPLACE (State or foreign country) Crompton, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Frank Simmons		14. MOTHER'S MAIDEN NAME Matilda Waddell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) --		16. SOCIAL SECURITY NO. 220-30-8814	
17. INFORMANT Webster Fugate		Address Benton Harbor, Mich.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic nephrosclerosis. 420.0 DUE TO Generalized arteriosclerosis. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease (c) Diabetic - Rt Femur - healed		INTERVAL BETWEEN ONSET AND DEATH years. 3 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell in back yard	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 12 Mid. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Hagerstown Wash. Md.	
21. I certify that (I) (this hospital) attended the deceased from Nov. 13 1961 to Nov. 14 1961 , that (I) (we) last saw the deceased alive on Nov. 13 1961 , and that death occurred at 5:20 M, from the causes and on the date stated above.			
22a. SIGNATURE Philip J. Hirshman		22b. DATE SIGNED 11/15/61	
22c. PHYSICIAN'S NAME (Type) Philip J. Hirshman, M.D.		22d. ADDRESS 159 W. Washington St. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-16-61	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son		25. REC'D BY REGISTRAR NOV 17 '61	
ADDRESS Hagerstown, md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

13198

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13182

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b life time	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 409 Suman Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Dianne Middle (None) Last Russ		4. DATE OF DEATH Month Nov Day 8 Year 19 61	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug 26 1950
9. AGE (In years lost birthday) 11 yrs.		10. IF UNDER 1 YEAR Months 11 Days 11 Hours 11 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Hagerstown, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William Russ		14. MOTHER'S MAIDEN NAME Nettie Burnett	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. None	
17. INFORMANT Nettie Russ 409 Suman Ave.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) aspiration pneumonitis 753.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Microcephalia DUE TO (c) 10 yrs		INTERVAL BETWEEN ONSET AND DEATH 3 days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Month, Day, Year Hour o. m. None p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State) - - -	
21. I certify that (I) (this hospital) attended the deceased from July 31 19 61 to Nov. 8 19 61 that (I) (we) last saw the deceased alive on Oct. 18 19 61 and that death occurred at 7A M, from the causes and on the date stated above.			
22a. SIGNATURE Harold R. Tritch, Jr		22b. DATE SIGNED 11-9-61	
22c. PHYSICIAN'S NAME (Type) Dr. Harold R. Tritch, Jr MD		22d. ADDRESS 302 N. Potomac Street -Hagerstown, Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-10-1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
24. FUNERAL DIRECTOR'S SIGNATURE John R. Watson Jr. Hagerstown Md.		25a. REC'D BY REGISTRAR DATE NOV 14 '61	
25b. REGISTRAR'S SIGNATURE Wm. S. Hines			

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THE BROWN OF DEATH

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Life Line, Georgetown, Maryland.

400 Green Ave, Georgetown, Md.

Life Line, Georgetown, Md.

Life Line, Georgetown, Md.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 18 Maryland State Department of Health—BALTIMORE, 18									
13199									
Certificate of Death									
Reg. Dist No. 13183									
1. PLACE OF DEATH a. COUNTY Washington, Ft Ritchie, Cascade MARYLAND					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington Allegany				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ft Ritchie, Md.			c. LENGTH OF STAY IN 1b 11/62-2		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fort Ritchie, Maryland Cumberland			d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION US Army Dispensary, Ft Ritchie, Md.					e. STREET ADDRESS Bldg. 400/ 22 Browning Street				
3. NAME OF DECEASED (Type or print) First Middle Last Raymond Lionel Schanholtz					4. DATE OF DEATH Month Day Year Nov 28 19 61				
5. SEX Male		6. COLOR OR RACE Cau		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH 28 Aug 1914		9. AGE (In years lost birthday) yrs. 47	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Cook			10b. KIND OF BUSINESS OR INDUSTRY US Army			11. BIRTHPLACE (State or foreign country) Green Spring, West Va.		12. CITIZEN OF WHAT COUNTRY? United States	
13. FATHER'S NAME Herbert R Schanholtz					14. MOTHER'S MAIDEN NAME Deceased				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) To present		17. INFORMANT From Army Records by WILLIAM T CUZICK, Capt, MSC		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 775.5 Cause of death unknown pending result of Toxicologic examination DUE TO (b) Respiratory failure secondary to cerebral depression DUE TO (c) of unknown etiology. (Autopsy report)								INTERVAL BETWEEN ONSET AND DEATH 2 hrs 20 Min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on 28 November , 19 61 , and that death occurred at 4:50 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Patrick J Ferraro Capt MC M.D. Fort Ritchie, Cascade, Maryland 28 Nov 61 PHYSICIAN'S NAME (Type) PATRICK J FERRARO, CAPT., MC Fort Ritchie, Md. US Army Dispensary									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/2/1961		22c. NAME OF CEMETERY OR CREMATORY Rest Lawn Memorial Cemetery		22d. LOCATION (City, town, or county) (State) Cumberland Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. Marlin Roe					ADDRESS Waynesboro, Penna.		24a. REC'D BY REGISTRAR DATE DEC 4 '61		24b. REGISTRAR'S SIGNATURE Arthur L. Haines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and correctly filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13200

CERTIFICATE OF DEATH

13184

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL L. CLEAR SPRING, MD. c. LENGTH OF STAY IN lb LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) RESIDENCE		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) RURAL 1, d. STREET ADDRESS CLEAR SPRING, MD. e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) FRANK OWEN SEIBERT		4. DATE OF DEATH 11/6/1961	
5. SEX MALE		6. COLOR OR RACE WHITE	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1/10/1872	
9. AGE (In years last birthday) 89 yrs.		10. IF UNDER 1 YEAR Months 9 Days 26	
11. BIRTHPLACE (County & State, or foreign country) WASHINGTON COUNTY		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CHARLES SEIBERT		14. MOTHER'S MAIDEN NAME ELIZABETH FOUKE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT FRANKLIN S. SEIBERT, ROUTE 1, CLSPG. MD.		Address	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CHRONIC MYOCARDITIS 420.0 DUE TO ARTERIOSCLEROTIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (b) (e), stating the underlying cause last. } DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 15, 1960, 19 to Nov. 6, 1961, 19 , that (I) (we) last saw the deceased alive on Nov. 2, 1961 19 , and that death occurred at 9:15 AM from the causes and on the date stated above.			
22a. SIGNATURE <i>Archie Robert Cohen</i> M.D.		22b. DATE SIGNED 11/07/61	
22c. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.		22d. ADDRESS Clear Spring, Maryland	

23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/8/1961		23c. NAME OF CEMETERY OR CREMATORY ST. PAULS CEMETERY		23d. LOCATION (City, town or county) (State) WESTERN PIKE, MD.	
24. FUNERAL DIRECTOR'S SIGNATURE <i>Margaret R. Rowland</i>		ADDRESS CLEAR SPRING, MD.		25a. REC'D BY REGISTRAR NOV 9 '61		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



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WASHINGTON

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RURAL 1, CINCINNATI, MO. 11/3/50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13201

CERTIFICATE OF DEATH

13185

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 11 Hrs. d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASHINGTON CO. HOSPITAL		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN d. STREET ADDRESS 232 BELL VUE AVE. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) NELLIE ROY SHANK		4. DATE OF DEATH Month NOV. Day 14 Year 19 61	
5. SEX FEMALE WHITE		6. COLOR OR RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH SEPT. 10, 1910 51 yrs. 9. AGE (In years last birthday) 2 Months 4 Days 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WORK 11. BIRTHPLACE (County & State, or foreign country) FRONT ROYAL, VA. 12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILBUR H. CAMERON		14. MOTHER'S MAIDEN NAME EDITH M. SIMONS	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NONE		16. SOCIAL SECURITY NO. NONE 17. INFORMANT RAYMOND E. SHANK 232 BELL VUE AVE. HAGERSTOWN, MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Dilatation, right ventricle 241X DUE TO Conditions, if any, which gave rise to immediate cause (b) Pulmonary Emphysema (a), stating the underlying cause last. DUE TO Bronchial Asthma (c)		INTERVAL BETWEEN ONSET AND DEATH 10 1/2 hours 18 months 18 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (M.D. or Physician) attended the deceased from Nov. 14, 1961 11:00 pm. Nov. 14, 1961 , that (I) (We) last saw the deceased alive on Nov. 14, 1961 , and that death occurred at 11:00 pm. M. from the causes and on the date stated above.		22a. SIGNATURE William T. Layman, M.D. 22b. DATE SIGNED 11-15-61	
22c. PHYSICIAN'S NAME (Type) William T. Layman, M.D.		22d. ADDRESS 100 Professional Arts Bldg. Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF 11/17/61	
23c. NAME OF CEMETERY OR CREMATORY SHANKTOWN CEMETERY		23d. LOCATION (City, town or county) (State) SHANKTOWN MD.	
24. FUNERAL DIRECTOR'S SIGNATURE Margaret R. Howland		25a. REC'D BY REGISTRAR NOV 21 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Evans	

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WASHINGTON

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WASHINGTON

WASHINGTON DC. HOSPITAL

222 WEST VIR. AVE.

WILLIE

JOHN

FRANK WHITE

JOHN WHITE

HOUSE WORK

HOUSE WORK

WILLIAM J. GARRON

ADITH J. SIMON

NO HOME

HOME

WILLIAM J. GARRON

ADITH J. SIMON

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filled in by the funeral director. After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

13202

DR. DITTO

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13186

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b 19 DAYS d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) WASH. Co. Hospital		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 116 NORTH CANNON AVENUE e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) HARRY L. SHEPLEY		4. DATE OF DEATH NOVEMBER 7 - 1961	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL 30 1888
9. AGE (In years last birthday) 73 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CUSTODIAN	
11. BIRTHPLACE (County & State, or foreign country) MYERSVILLE FRED. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN C. SHEPLEY		14. MOTHER'S MAIDEN NAME SUSAN GROSSNICKLE	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) No		16. SOCIAL SECURITY NO. 217-10 3160	
17. INFORMANT EDWARD SHEPLEY		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 421.4 DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Active chronic obstructive pulmonary disease (c) now PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 10 days 5 yrs	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Oct 7 - 1961 to Nov 7 - 1961 , that (I) (we) last saw the deceased alive on Nov 7 - 1961 , and that death occurred 11 A.M. from the causes and on the date stated above.			
22a. SIGNATURE S. E. W. Dittus		22b. DATE SIGNED Nov 7 - 1961	
22c. PHYSICIAN'S NAME (Type) Dr. E. W. Dittus Jr.		22d. ADDRESS Hagerstown Md	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 9 1961	
23c. NAME OF CEMETERY OR CREMATORY FAIRVIEW CEMETERY		23d. LOCATION (City, town or county) (State) KEEDYSVILLE WASH. Co. MD.	
24. FUNERAL DIRECTOR'S SIGNATURE John H. Bast		25a. REC'D BY REGISTRAR NOV 13 61	
25b. REGISTRAR'S SIGNATURE Arthur A. Hanks		25c. ADDRESS BOONSBORO MD	

VR A15 (4)

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DEATH DATE OF DEATH

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FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13187											
1. PLACE OF DEATH a. COUNTY Washington MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hancock						c. LENGTH OF STAY in 1b Life					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Route 522 in Corp. limits						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hancock Maryland					
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						d. STREET ADDRESS					
3. NAME OF DECEASED (Type or print) Roscoe Quincy Shives						4. DATE OF DEATH Month 11 Day 29 Year 19 61					
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6.19.1892		9. AGE (In years last birthday) 69 yrs.		IF UNDER 1 YEAR Months 11 Days 29 Hours 19 Min. 61	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Tax Collector				10b. KIND OF BUSINESS OR INDUSTRY Tax Collector				11. BIRTHPLACE (State or foreign country) Hancock Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William H Shives						14. MOTHER'S MAIDEN NAME Elizabeth Andrews					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 216.14.5992				17. INFORMANT Mrs Maude L Shives Hancock Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c) Ischemic											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				INTERVAL BETWEEN ONSET AND DEATH 6 yrs							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE A. E. W. J. [Signature]				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED 11/29/61			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
				Address (Street, city, town, or county)							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12.2.61		22c. NAME OF CEMETERY OR CREMATORIUM Warfordsburg Presbyterian		22d. LOCATION (City, town, or country) (State) Warfordsburg Fulton Penn			
23. FUNERAL DIRECTOR Howard J. [Signature]				ADDRESS		24a. REC'D BY REGISTRAR DEC 4 '61		24b. REGISTRAR'S SIGNATURE Arthur J. [Signature]			



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William B. Shiver

Joseph B. Shiver

The 18503 is made of silver

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13204

CERTIFICATE OF DEATH

Reg. Dist. No. 13188

1. PLACE OF DEATH o. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Frederick</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro</u>		c. LENGTH OF STAY IN 1b <u>5 years</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Reeder Nursing Home</u>		d. STREET ADDRESS <u>10X-2</u>	
3. NAME OF DECEASED (Type or print) First <u>Sarah</u> Middle <u>B.</u> Last <u>Slifer</u>		4. DATE OF DEATH Month <u>11</u> Day <u>4</u> Year <u>1961</u>	
5. SEX <u>female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/1874</u>
9. AGE (In years lost birthday) <u>87</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Charles Slifer</u>		14. MOTHER'S MAIDEN NAME <u>M. Anna Gans</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	
17. INFORMANT <u>Mrs. H.B. White, Yardley, Pa.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiovascular collapse</u> <u>422</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>gm</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>min.</u> <u>hr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>60</u> , to <u>Nov 4</u> , 19 <u>61</u> , that I last saw the deceased alive on <u>Nov 1</u> , 19 <u>61</u> , and that death occurred at <u>8:45 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Louis G. Craff</u> M.D.		ADDRESS (Street, city or town, state) <u>119 E. Antietam</u> DATE SIGNED <u>11/5/61</u>	
PHYSICIAN'S NAME (Type) <u>Louis G. Craff</u>		<u>Hagerstown, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>	22b. DATE THEREOF <u>11/6/1961</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Union Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Burkittsville, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gladhill Company, Middletown, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 7 '61</u>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13205

CERTIFICATE OF DEATH

13189

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 2 mo. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Western Md. State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Highfield d. STREET ADDRESS Box 114 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) CHARLES EDGAR SMITH		4. DATE OF DEATH Month NOV Day 15 Year 1961	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 8, 1885
9. AGE (In years last birthday) 76 yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rail Road	11. BIRTHPLACE (County & State, or foreign country) Frederick Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Charles W. Smith	
14. MOTHER'S MAIDEN NAME Elizabeth Warner		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) no	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Alma L. Smith Address Highfield, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary embolus (c) Arteriosclerotic Heart Disease		INTERVAL BETWEEN ONSET AND DEATH few minutes unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(e) (1) Paralysis Agitans (2) Hypertensive Cardiovascular Disease			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Highfield		(County) Washington	
(State) Md.		21. I certify that (I) (this hospital) attended the deceased from 9-13-61 , 1961, to 11-15- , 1961, that (I) (was) last saw the deceased alive on 11-15-1961 , and that death occurred at 11:48 PM , from the causes and on the date stated above.	
22a. SIGNATURE Victor L. Ramos, M.D.		22b. DATE SIGNED NOV 20 '61	
22c. PHYSICIAN'S NAME (Type) VICTOR L. RAMOS, M.D.		22d. ADDRESS 1500 PA AVE HAGERSTOWN MD.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/18/61	
23c. NAME OF CEMETERY OR CREMATORY Bethel		23d. LOCATION (City, town or county) Washington Co., Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Katherine Z. Grove		25a. REC'D BY REGISTRAR DATE NOV 20 '61	
ADDRESS Haynesboro, Pa.		25b. REGISTRAR'S SIGNATURE Arthur S. Kline	

(M)

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Washington

No.

Washington

Laguardia

2 no.

Hickfield

Western Md. State Hospital

Box 114

Wife

Wife

Aug. 3, 1985

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Ball Road

Western Md.

Frederick Co., Md.

U.S.A.

Charles W. Smith

Elizabeth Warner

Mrs. Alice L. Smith

Hickfield, Md.

Permanently employed

Permanently employed

Washington State Hospital

Director of Hospital

Director of Hospital

Revised

11/18/81

Revised

Washington State Co., Md.

Director of Hospital

13206

1
MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13190

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN 1b 35 years			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Goldie Elizabeth Smith				4. DATE OF DEATH Month Day Year November 5 1961			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 13, 1898	
9. AGE (In years lost birthday) yrs. 63		10. IF UNDER 1 YEAR Months Days Hours Min. 63		11. IF UNDER 24 HRS. Months Days Hours Min. 63		12. CITIZEN OF WHAT COUNTRY? Penn.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife				10b. KIND OF BUSINESS OR INDUSTRY Own Home			
11. BIRTHPLACE (State or foreign country) Cito Penn.				12. CITIZEN OF WHAT COUNTRY? Penn.			
13. FATHER'S NAME George W. Mayhugh				14. MOTHER'S MAIDEN NAME Anna Carbaugh			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) ---				16. SOCIAL SECURITY NO. ---			
17. INFORMANT Mrs. Patsy Amsley				Address Hagerstown, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis DUE TO (c) ?							INTERVAL BETWEEN ONSET AND DEATH 1 hour ? 10 yr
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Hagerstown				(County) (State)			
21. I certify that (I) (this hospital) attended the deceased from Oct 27 19 61 to Nov 5 19 61 , that (I) (we) last saw the deceased alive on Nov 5 19 61 , and that death occurred on 11-20-61 from the causes and on the date stated above.							
22a. SIGNATURE Robert Vh Campbell				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/7/61	
22c. PHYSICIAN'S NAME (Type) Robert Vh. Campbell				22d. ADDRESS Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-8-61		23c. NAME OF CEMETERY OR CREMATORY Brethern Church Cem.		23d. LOCATION (City, town, or county) (State) Welsh Run, Penn.	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 9 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
13207 CERTIFICATE OF DEATH 13191

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN life most of life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		d. STREET ADDRESS 1422 Potomac Ave.	
3. NAME OF DECEASED (Type or print) JESSIE LORENA SMITH		4. DATE OF DEATH November 25 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH February 1, 1900
9. AGE (In years last birthday) 61 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Clerk		10b. KIND OF BUSINESS OR INDUSTRY Circuit Court	
11. BIRTHPLACE (County & State, or foreign country) Wilson District, Md.		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME George S. Fockler		14. MOTHER'S MAIDEN NAME Laura Kate Mitchell	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 220-18-0025	
17. INFORMANT George H. Smith		Address Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardio Vascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 2 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from NOV. 25, 1961 , to NOV. 25, 1961 , that (I) (we) last saw the deceased alive on NOV. 25, 1961 , and that death occurred at 3 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Lloyd A. Hoffman		22b. DATE SIGNED 11/27/61	
22c. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		22d. ADDRESS 214 N. Potomac St. Hagerstown, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/28/1961	
23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cemetery		23d. LOCATION (City, town or county) (State) St. Paul's Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE R. Franklin Henger		25a. REC'D BY REGISTRAR DAT NOV 29 '61	
ADDRESS Hagerstown, Md.		25b. REGISTRAR'S SIGNATURE Arthur S. Hines	

(M)

(1)

Washington

Washington

Washington

Washington

Washington

Washington

Washington County Hospital

Washington Ave.

Female

Female

Female

Female

Female

White

February 1, 1900

County Clerk

Wilson District, D.C.

George S. Tucker

James Lee Tucker

200-1-2002

George W. Smith

Washington, D.C.

Myocardial Infarction

Myocardial Infarction

Nov 22, 1900

Nov 22, 1900

Nov 22, 1900

Nov 22, 1900

Nov 22, 1900

Nov 22, 1900

Nov 22, 1900

11/25/1901

St. Paul's Cemetery

St. Paul's

St. Paul's

St. Paul's Cemetery

St. Paul's Cemetery

St. Paul's Cemetery

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13208

13192

1. PLACE OF DEATH a. COUNTY Washington MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport RFD2 c. LENGTH OF STAY IN 1b 20 yrs. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pinesburg				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland Washington b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport RFD #2 d. STREET ADDRESS Pinesburg e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Bertha Mary Staley		4. DATE OF DEATH Month Nov. Day 5 Year 19 61		5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH July 17 1888 9. AGE (In years last birthday) 73 yrs. 10. IF UNDER 1 YEAR Months 3 Days 18 11. IF UNDER 24 HRS. Hours Min. 			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maker Rubber Heels 10b. KIND OF BUSINESS OR INDUSTRY Rubber Co.		11. BIRTHPLACE (County & State, or foreign country) Williamsport Md. 12. CITIZEN OF WHAT COUNTRY? U. S. A		13. FATHER'S NAME John Chrisman 14. MOTHER'S MAIDEN NAME Sarah Rowe			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No 16. SOCIAL SECURITY NO. 220 18 3107 17. INFORMANT Doris Hareford Address Pinesburg Williamsport Md RFD #2		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4201 Ac. Myocardial Infarction INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE DUE TO (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) 					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) 					
20c. TIME OF INJURY Month, Day, Year 11/5/61 Hour a.m. 19 p.m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) Williamsport (County) Maryland (State) 			
21. I certify that (I) (this hospital) attended the deceased from 11/5/61 to 11/5/61 that (I) (we) last saw the deceased alive on 11/5/61 and that death occurred 11/6/61 from the causes and on the date stated above.							
22a. SIGNATURE Ralph E. Young M.D. 22b. DATE SIGNED 11/6/61		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Williamsport, Maryland					
22c. PHYSICIAN'S NAME (Type) Ralph E. Young		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF Nov. 7-61 23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery 23d. LOCATION (City, town or county) Williamsport Md. (State) 					
24. FUNERAL DIRECTOR'S SIGNATURE Albert L. Leaf ADDRESS Williamsport, Md.		25a. REC'D BY REGISTRAR NOV 8 '61 25b. REGISTRAR'S SIGNATURE Arthur S. Kraus					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



13308

11108

Washington

Maryland

Washington

Paul Williamsport MD 20 yrs.

Paul Williamsport MD 20 yrs.

Pineburg

Pineburg

Perkins

Perkins

Staley

Nov.

5

61

Perkins White

July 17 1888 73

3 18

Raker Rubber Heals Rubber Co. Williamsport Md. U. S. A.

Raker Howe

John Christian

320 18 2107 Doris Hareford MD 20 22
Pineburg Williamsport

20

Williamsport, Maryland

Ralph F. Young

Nov. 1-61 Greenham Cemetery Williamsport Md.

Williamsport, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

1
13209
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No. 13193

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pa. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 Month	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. STREET ADDRESS 37 N. Main St.	
3. NAME OF DECEASED (Type or print) First Martha Middle B. Last Stouffer		4. DATE OF DEATH Month Nov. Day 3, Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 6/20/1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Waynesboro, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Freeland W. Anderson		14. MOTHER'S MAIDEN NAME Margaret K. Snodderly	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No.		16. SOCIAL SECURITY NO.	
17. INFORMANT Mrs. Wolfinger, Smithsburg Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Death Myocardial Infarction 420 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) arteriosclerotic heart disease DUE TO (c) many years INTERVAL BETWEEN ONSET AND DEATH 24 hrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from November 2, 1961 , to November 3, 1961 , that I last saw the deceased alive on November 3, 1961 , and that death occurred at 10:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 So Prospect St Hagerstown Md DATE SIGNED			
ACTUAL SIGNATURE Edsen B Moody M.D.		PHYSICIAN'S NAME (Type) Edsen B Moody	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/5/61	22c. NAME OF CEMETERY OR CREMATORY Green Hill	22d. LOCATION (City, town, or county) (State) Waynesboro, Franklin Co., Pa.
23. FUNERAL DIRECTOR'S SIGNATURE Walter J. Shove, Waynesboro Pa.		ADDRESS	
24a. REC'D BY REGISTRAR DATE NOV 6 '61		24b. REGISTRAR'S SIGNATURE C. Thum & Thum	



may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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13210

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13194

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown c. LENGTH OF STAY IN 1b 5 1/2 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Northern Ave.			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash. c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS Northern Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First George Middle Loenholt Last Strong			4. DATE OF DEATH Month Nov. Day 18, Year 19 61		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 29, 1910	9. AGE (In years last birthday) 51 yrs.	IF UNDER 1 YEAR Months 51 Days 18 Hours 19 Min. 61
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) civil engineer		10b. KIND OF BUSINESS OR INDUSTRY construction work		11. BIRTHPLACE (State or foreign country) Tokyo, Japan	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME George V. Strong		
14. MOTHER'S MAIDEN NAME Gerda Loenholt			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes (If yes, give war or dates of service) WW II		
16. SOCIAL SECURITY NO. 579-05-6057			17. INFORMANT Mrs. Mary Strong, Hagerstown, Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 42010 DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease DUE TO (c) 1 hr.					INTERVAL BETWEEN ONSET AND DEATH 1 hr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Neurodermatitis					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from 18 JAN. to 18 Nov. 19 61 , that (I) (we) last saw the deceased alive on 18 Nov. 19 61 , and that death occurred at M. from the causes and on the date stated above.					
22a. SIGNATURE Richard T. Binford		22b. ADDRESS 1135 POTOMAC AVENUE, HAGERSTOWN, MD.		22c. DATE SIGNED 20 Nov. 1961	
22d. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		22e. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 11-22-61	23c. NAME OF CEMETERY OR CREMATORY Arlington Nat. Cem.	23d. LOCATION (City, town, or county) (State) Ft. Myer, Va.		
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 22 '61		25b. REGISTRAR'S SIGNATURE Arthur L. Kline	

M

13210

CERTIFICATE OF DEATH

13131

1 in
from

Continued heart failure
Myocardial infarction

Remains in situ;

Richard E. Bunker

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

13211

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13195

1. PLACE OF DEATH a. COUNTY <u>Washington</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> c. LENGTH OF STAY IN lb <u>20 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>22 North Potomac Street</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u> d. STREET ADDRESS <u>22 North Potomac Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First <u>Guy</u> Middle <u>Thornton</u> Last <u>Stultz</u>				4. DATE OF DEATH Month <u>November</u> Day <u>7</u> Year <u>19 61</u>									
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 8, 1895</u>		9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Janitor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>				11. BIRTHPLACE (State or foreign country) <u>USA</u>				12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Joseph Stultz</u>				14. MOTHER'S MAIDEN NAME <u>Nonnie Anders</u>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>World War I</u>				16. SOCIAL SECURITY NO. <u>217-18-7213</u>		17. INFORMANT <u>Mrs. Clara Beans</u>		Address <u>Frederick, Maryland</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion of circumflex and</u> <u>420.1</u> DUE TO <u>right coronary vessels</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>Advanced atherosclerosis severe</u> (c) <u> </u> INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u> <u>10 years</u>													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive cardiovascular disease</u>													
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u> </u> <u> </u> <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>Edward W. Ditto III</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> Act. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <u>11/7/61</u>					
EXAMINER'S NAME (Type) <u>Edward W. Ditto III, M. D.</u>													
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/11/61</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Rocky Hill</u>				22d. LOCATION (City, town, or county) (State) <u>Rural Woodsboro MD</u>					
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. C. Barton</u>				ADDRESS <u>Walkersville</u>				24a. REC'D BY REGISTRAR <u>NOV 10 '61</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1951

NAME OF DECEASED JAMES EARL RAY		AGE 35		SEX Male		RACE White	
DATE OF DEATH April 4, 1968		PLACE OF DEATH Memphis, Tennessee		CITY Memphis		STATE Tennessee	
OCCUPATION Attorney		EDUCATION High School Graduate		MARRIAGE Married		RELIGION Methodist	
CAUSE OF DEATH Suicide		MANNER OF DEATH Homicide		TOXICOLOGY None		ALCOHOL None	
SIGNATURE OF EXAMINER [Signature]		DATE April 4, 1968		TIME 10:00 AM		PLACE [Signature]	
FINGERPRINTS [Fingerprints]		PHOTOGRAPH [Photograph]		X-RAY [X-Ray]		LABORATORY [Laboratory]	
HISTORICAL DATA [Text]		PHYSICAL DATA [Text]		MENTAL DATA [Text]		SOCIAL DATA [Text]	
FAMILY HISTORY [Text]		PREVIOUS ILLNESS [Text]		MEDICATION [Text]		TREATMENT [Text]	
PATHOLOGICAL DATA [Text]		MICROSCOPIC DATA [Text]		BACTERIOLOGICAL DATA [Text]		VIROLOGICAL DATA [Text]	
GROSS ANATOMY [Text]		HISTOPATHOLOGY [Text]		IMMUNOLOGY [Text]		CYTOLOGY [Text]	
NEUROLOGY [Text]		ENTOMOLOGY [Text]		ANTHROPOLOGY [Text]		FORENSIC DATA [Text]	
LABORATORY DATA [Text]		TOXICOLOGY DATA [Text]		ALCOHOL DATA [Text]		DRUG DATA [Text]	
RADIOLOGY DATA [Text]		PATHOLOGY DATA [Text]		PHYSIOLOGY DATA [Text]		PSYCHOLOGY DATA [Text]	
SOCIAL DATA [Text]		FAMILY DATA [Text]		EDUCATION DATA [Text]		OCCUPATION DATA [Text]	
MARRIAGE DATA [Text]		RELIGION DATA [Text]		POLICE DATA [Text]		PROSECUTION DATA [Text]	
DEFENSE DATA [Text]		JURY DATA [Text]		VERDICT DATA [Text]		SENTENCE DATA [Text]	
APPEAL DATA [Text]		REVIEW DATA [Text]		REVISION DATA [Text]		CORRECTION DATA [Text]	
REMARKS [Text]		REMARKS [Text]		REMARKS [Text]		REMARKS [Text]	

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13212

13196

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown Rt. #2 c. LENGTH OF STAY IN 1b 4 Mos. d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Gateway Conv. Home			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Hagerstown d. STREET ADDRESS 1497 Salem Ave. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First ALBERT Middle LEWIS Last TROUPE			4. DATE OF DEATH Month November Day 29 Year 1961		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH October 11, 1889	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months 24 Days 11 Hours 11 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Yardman		10b. KIND OF BUSINESS OR INDUSTRY Jamison Door Co.		11. BIRTHPLACE (County & State, or foreign country) Funkstown, Wash. Co. Md.	
12. CITIZEN OF WHAT COUNTRY? USA.			13. FATHER'S NAME Scott Troup e		
14. MOTHER'S MAIDEN NAME Ella (No Record)			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes give war or dates of service) W.W.#1		
16. SOCIAL SECURITY NO. 317-09-9546			17. INFORMANT Mrs. Lewis Penner Address Hagerstown, Maryland. 1497 Salem Ave.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chr. Cardiac Disease 434.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 year DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Prostatic Hypertrophy					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from Sept 1, 1961 to Nov 29, 1961 that (I) (we) last saw the deceased alive on Nov 28, 1961 and that death occurred at 12:11 from the causes and on the date stated above.					
22a. SIGNATURE David R. Brewer M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 11/30/61
22c. PHYSICIAN'S NAME (Type) David R. Brewer		22d. ADDRESS Clear Spring Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF 12/1/61	23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery	23d. LOCATION (City, town or county) (State) Hagerstown, Maryland.		
24. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman		ADDRESS Hagerstown, Maryland.		25a. REC'D BY REGISTRAR DEC 4 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Hume

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1, 2, 3, and 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13213

CERTIFICATE OF DEATH

13197

1. PLACE OF DEATH a. COUNTY Washington b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rural Clearspring c. LENGTH OF STAY IN 1b 11 years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) R.F.D. # 1		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Washington c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Clearspring d. STREET ADDRESS R.F.D. # 1 a. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First GERTRUDE Middle ELIZABETH Last VANCE		4. DATE OF DEATH Month November Day 12 Year 1961	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 13, 1869
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) Washington Co., Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Lewis Schnebly	
14. MOTHER'S MAIDEN NAME Mary C. Middlekauff		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or (unknown) (If yes, give war or dates of service) no	
16. SOCIAL SECURITY NO. none		17. INFORMANT Address Mrs. Catherine Roney Clearspring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) BRONCHO PNEUMONIA DUE TO 491X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE		INTERVAL BETWEEN ONSET AND DEATH 6 DAYS	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour 0 e.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from NOV 8 1961 to NOV 12 1961 , that (I) (we) last saw the deceased alive on NOV 11 1961 , and that death occurred at 11:35 AM from the causes and on the date stated above.			
22a. SIGNATURE Archie Robert Cohen M.D.		22b. DATE SIGNED 11-13-61	
22c. PHYSICIAN'S NAME (Type) ARCHIE ROBERT COHEN, M.D.		22d. ADDRESS CLEAR SPRING, MARYLAND	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/14/1961	
23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery		23d. LOCATION (City, town or county) (State) Hagerstown Md.	
24. FUNERAL DIRECTOR'S SIGNATURE Suter - Rouzer Funeral Home ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR NOV 16 '61	
25b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

1951

(M)

Washington

United States

1951

White

United States

none

BRANCH THE UNION

HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE

1951

RODIE ROBERT COHEN, M.D. CLARK SPRING, MARYLAND

1951

1951

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

13214

CERTIFICATE OF DEATH

13198

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN lb <u>6mo.5 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Boonsboro (Rural)</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Western Maryland State Hospital</u>				d. STREET ADDRESS <u>Boonsboro RFD #1</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>CLEVELAND GROVER WALKER</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>2</u> Year <u>1961</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 13 1884</u>	
9. AGE (In years last birthday) <u>76</u> yrs.		IF UNDER 1 YEAR Months <u>11</u> Days <u>19</u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Skeiner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Silk Mill</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Falling Waters W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>							
13. FATHER'S NAME <u>Daniel Walker</u>				14. MOTHER'S MAIDEN NAME <u>Annie Walters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>234 22 6820</u>		17. INFORMANT <u>628 Antietam Drive Mr. Samuel Walker Hagerstown Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Carcinoma of the prostate with vesical neck obstruction</u> DUE TO (c) <u>Unknown</u> 177X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Arteriosclerotic heart disease</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u></u> a.m. <u></u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>4-27-1961</u> to <u>11-2-1961</u> , that (I) (was) last saw the deceased alive on <u>11-2-1961</u> , and that death occurred at <u>539</u> M, from the causes and on the date stated above.							
22a. SIGNATURE <u>Young E. Chun</u> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>11-2-1961</u>	
22c. PHYSICIAN'S NAME (Type) <u>YOUNG E. CHUN</u>				22d. ADDRESS <u>1500 Penna Ave Hagerstown Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 4-61</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Near Clearspring Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Albert L. Leaf</u>				ADDRESS <u>201 Wilkinsport, Md</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 6 '61</u>	
				25b. REGISTRAR'S SIGNATURE <u>Orthur S. Hume</u>			

(M)

(I)

1931

Washington

Hamersburg

Western Maryland State Hospital

Hamersburg, Md.

Male

White

X

Nov. 13 1884

11 19

Shelton

State Mill

Falling Waters, W. Va.

Daniel Walker

Anna Walker

228 22 2820 Mr. Daniel Walker Hamersburg, Md.

No

Nov. 13 1884

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

Items 7 & 23 Film G302 12/13/61 iwk

13199

1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If Institution; Residence before admission) e. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 645 years			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 201 Ross St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Nora Middle Elsie Last Weaver				4. DATE OF DEATH Month Nov. Day 29, Year 19 61			
5. SEX female		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH July 30, 1882	
9. AGE (In years last birthday) 79 yrs.		IF UNDER 1 YEAR Months 7 Days 19		IF UNDER 24 HRS. Hours 19 Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house work				10b. KIND OF BUSINESS OR INDUSTRY			
11. BIRTHPLACE (County & State, or foreign country) Edgemont, Wash.Co., Md.				12. CITIZEN OF WHAT COUNTRY?			
13. FATHER'S NAME David Shank				14. MOTHER'S MAIDEN NAME Clara Miller			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give year or dates of service)				16. SOCIAL SECURITY NO. 220-34-0838			
17. INFORMANT Howard W. Weaver, Hagerstown, Md.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCT 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) Generalized Atherosclerosis (c) 425 PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour e.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (the hospital) attended the deceased from 11-26 , 19 61 , to 11-29 , 19 61 , that (I) (we) last saw the deceased alive on 11-26 , 19 61 , and that death occurred at 7:20 P.M. from the causes and on the date stated above.							
22a. SIGNATURE Harold R. Tritch Jr M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-30-61	
22c. PHYSICIAN'S NAME (Type) HAROLD R. TRITCH JR MD				22d. ADDRESS 301 N. DOWNE ST. HAGERSTOWN MD			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12/2/61		23c. NAME OF CEMETERY OR CREMATORY Millers Church Cemetery		23d. LOCATION (City, town or county) (State) Leitersburg, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.				ADDRESS DEC 6 '61		25a. REC'D BY REGISTRAR Arthur S. Hume	
25b. REGISTRAR'S SIGNATURE							



18815

18815

Washington

Harveston

Harveston

201 Ross St.

201 Ross St.

NOTE

NOTE

female white

female white

house work

house work

David Shank

David Shank

220-2-0838

220-2-0838

no

no

no

no

no

no

no

no

no

no

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no

no

no

no

no

no

no

no

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no

no

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. If 24 hours may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
13216 CERTIFICATE OF DEATH 13200									
1. PLACE OF DEATH a. COUNTY Washington MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Md. b. COUNTY Wash.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. LENGTH OF STAY in 1b 4 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Wilson Blvd.					d. STREET ADDRESS 1			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Samuel Franklin Webb.					4. DATE OF DEATH Month Nov. Day 30, Year 19 61				
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 10, 1881		9. AGE (In years last birthday) 80 yrs.	
						IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) labor				10b. KIND OF BUSINESS OR INDUSTRY farming		11. BIRTHPLACE (County & State, or foreign country) Foxville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME James Webb					14. MOTHER'S MAIDEN NAME Rose Anne Baker				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no				16. SOCIAL SECURITY NO. 213-12-7185		17. INFORMANT Address Mrs. Josephine Stevens, Hag., Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Failure 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								INTERVAL BETWEEN ONSET AND DEATH 30 Days 10 Yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)								20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3-18 , 1961 , to 11-30 , 1961 , that (I) (we) last saw the deceased alive on 11-18 , 1961 , and that death occurred at 2:45 AM, from the causes and on the date stated above.									
22a. SIGNATURE Charles F. Hess M.D.					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11-30-61		
22c. PHYSICIAN'S NAME (Type) Charles F. Hess M.D.					22d. ADDRESS Smithsburg, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE THEREOF 12-2-61		23c. NAME OF CEMETERY OR CREMATORY Mt. Bethel Cemetery		23d. LOCATION (City, town or county) (State) Frederick Co., Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smsithsburg, Md					ADDRESS DATE DEC 4 '61		25a. REC'D BY REGISTRAR Arthur S. Kraus		
					25b. REGISTRAR'S SIGNATURE				

1881

1881

Washington

May

Smithsonian

Woods

Legation

Wilson River

Franklin

Wood

Oct. 10, 1881

White

Wife

Station

Factor

Excellence

Howe Anne Lake

James Webb

215-12-1185 Mrs. Jonathan Stevens, Md.

no

Frederick Co., Md.

St. Michael Cemetery

12-2-81

Butler

Scott & Minnich & Son, Smithsburg, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13217

13201

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>WASH. COUNTY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>ZITTELSTOWN RURAL LIFE</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>X ZITTELSTOWN MD. RURAL</u> d. STREET ADDRESS <u>1 BOONSBORO MD. R.2</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>PATRICIA ANN WITEK</u>		4. DATE OF DEATH <u>NOVEMBER 29 1961</u>		5. SEX <u>FEMALE</u>	
6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPTEMBER 16 1961</u>	
9. AGE (in years last birthday) <u>0</u> yrs. <u>2</u> months <u>13</u> days		10. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>WASH. CO. HOSPITAL HAGERSTOWN MD. U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>LESTER WITEK</u>		14. MOTHER'S MAIDEN NAME <u>LOLA MONCAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>LESTER WITEK BOONSBORO MD. R.2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ASPHYXIA</u> 762.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) _____ (c) _____		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 1/2 weeks</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Medical exam was held for</u>			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	
20f. (City or town) _____ (County) _____ (State) _____		21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>61</u> , to <u>Nov</u> , 19 <u>61</u> , that (I) (we) last saw the deceased alive on <u>Nov 27 1961</u> , and that death occurred at <u>9A</u> M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Joseph Secondary</u>		22b. DATE SIGNED _____		22c. PHYSICIAN'S NAME (Type) <u>JOSEPH SECONDARY</u>	
22d. ADDRESS <u>Boonsboro Md</u>		22e. ADDRESS <u>Boonsboro Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>DEC. 1, 1961</u>		23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>	
23d. LOCATION (City, town or county) <u>Boonsboro WASH. CO. MD.</u>		23e. LOCATION (City, town or county) (State) _____			
24. FUNERAL DIRECTOR'S SIGNATURE <u>John N. Bast</u>		24b. ADDRESS <u>Boonsboro MD.</u>		25a. REC'D BY REGISTRAR <u>DEC 6 '61</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kline</u>		25c. REGISTRAR'S SIGNATURE _____			

2081181XV5

1931

1931

(M)

(C)

(A)

Page 1 of 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. Page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

13218

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

13202

1. PLACE OF DEATH a. COUNTY <u>WASHINGTON</u> <u>MARYLAND</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HALF WAY RURAL</u> c. LENGTH OF STAY IN TB <u>14 YEARS</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>WILLIAMSPORT R-2</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WASHINGTON</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>HALF WAY RURAL</u> d. STREET ADDRESS <u>WILLIAMSPORT MD. R. 2</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>FRANK ELLSWORTH WOLFE</u>			4. DATE OF DEATH <u>NOVEMBER 27 1961</u>		
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>			8. DATE OF BIRTH <u>MARCH 5 1903</u> 9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR: Months <u>8</u> Days <u>22</u> Hours <u></u> Min. <u></u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>GENERAL FARM WORK</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>WASHINGTON COUNTY MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>SHERMAN E. WOLFE</u>			14. MOTHER'S MAIDEN NAME <u>DOLLY SUMMERS</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>219-05-9907</u>		
17. INFORMANT <u>FRANKLIN E. WOLFE</u> Address <u>SMITHSBURG R. 2.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Cardio-Renal Disease</u> (c) <u>Scarlet Fever</u> <u>at 10 yrs</u>			INTERVAL BETWEEN ONSET AND DEATH <u>4 min.</u> <u>40 yrs</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>July 13 1961</u> to <u>Nov 20 1961</u> that (I) <u>(we)</u> last saw the deceased alive on <u>Nov 20 1961</u> , and that death occurred at <u>7 p.m.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>J.M. Baxter</u> M.D.			22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>J.M. Baxter M.D.</u>			22d. ADDRESS <u>4 East Church St. Frederick, Md.</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			23b. DATE THEREOF <u>NOV 30 1961</u>		
23c. NAME OF CEMETERY OR CREMATORY <u>BOONSBORO CEMETERY</u>			23d. LOCATION (City, town or county) (State) <u>BOONSBORO WASH. Co MD</u>		
24. FUNERAL DIRECTOR'S SIGNATURE <u>John H. Best</u>			25a. REC'D BY REGISTRAR <u>DEC 6 '61</u>		
ADDRESS <u>BOONSBORO MD</u>			25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>		

81581

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13219

13203

1. PLACE OF DEATH a. COUNTY WASHINGTON b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) HAGERSTOWN c. LENGTH OF STAY IN 1b LIFE d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 109 E. FRANKLIN ST.		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) e. STATE MARYLAND f. COUNTY WASHINGTON c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) 03 HAGERSTOWN d. STREET ADDRESS 109 E. FRANKLIN ST. e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First CLARA Middle VIRGINIA Last ZAHN		4. DATE OF DEATH Month NOVEMBER Day 10 Year 1961	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/16/1883
9. AGE (In years last birthday) 78 yrs.		IF UNDER 1 YEAR Months 7 Days 10	IF UNDER 24 HRS. Hours 10 Min. 19
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (County & State, or foreign country) MARYLAND
13. FATHER'S NAME WILLIAM A. NEWMAN		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, name unknown) NO (If yes give war or dates of service)		16. SOCIAL SECURITY NO. NONE	17. INFORMANT Address HAGERSTOWN MD. MR. CHARLES W. ZAHN SR.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. 4201 (b) Arteriosclerotic heart disease DUE TO (c) Hypertensive vascular disease			INTERVAL BETWEEN ONSET AND DEATH 15 min. Indefinite Indefinite
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 4:30p. Nov. 9, 1961 to Nov. 10, 1961 , that (I) (we) last saw the deceased alive on Nov. 9, 1961 , and that death occurred at 4:30p. M, from the causes and on the date stated above.			
22a. SIGNATURE B. B. Kneisley M.D.		22b. DATE SIGNED 11/13/61	
22c. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		22d. ADDRESS 148 West Washington Street Hagerstown, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE THEREOF 11/13/61	23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.	23d. LOCATION (City, town or county) (State) HAGERSTOWN MD.
24. FUNERAL DIRECTOR'S SIGNATURE W. J. Norman ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE NOV 14 '61	25b. REGISTRAR'S SIGNATURE Arthur S. Thomas

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

13242

13226

| | | | | | | | |
|---|--|---|--|---|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN lb <u>2500 days</u>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
e. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rhodesdale</u>
d. STREET ADDRESS <u>Box 44; RFD 1</u> | | | |
| 3. NAME OF DECEASED
(Type or print) <u>Marjorie</u> <u>Ella</u> <u>Haycraft</u> | | | | 4. DATE OF DEATH
<u>November</u> <u>8</u> <u>19 61</u> | | | |
| 5. SEX
<u>Female</u> | | 6. COLOR OR RACE
<u>White</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH
<u>5-18-1903</u> | | 9. AGE (In years last birthday) <u>58</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | | 11. BIRTHPLACE (County & State, or foreign country) <u>Madelia, Minn.</u> | |
| 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | | | | 13. FATHER'S NAME <u>James B. Haycraft</u> | | | |
| 14. MOTHER'S MAIDEN NAME <u>Sarah Woodhall</u> | | | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> | | | |
| 17. INFORMANT <u>May Haycraft, 92 Kenney Avenue</u>
<u>Sharon Hill, Pa.</u> | | | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic pyelonephritis</u>
DUE TO (b) <u>600.0</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>600.0</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Rheumatoid arthritis, multiple; diabetes mellitus</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State) | | | |
| 21. I certify that (If (this hospital) attended the deceased from Jan. 4, 1955 to Nov. 8, 1961, that (I) (we) last saw the deceased alive on Nov. 8, 1961, and that death occurred at 3:15 P.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <u>L. V. Maldve</u> 22b. DATE SIGNED <u>11/9/61</u> | | | | 22c. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M.D.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>11-13-61</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY <u>Phila. Memorial Park</u> 23d. LOCATION (City, town or county) (State) <u>Frazer, Pa.</u> | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Selmar, Del</u> 25a. REC'D BY REGISTRAR <u>NOV 14 '61</u> | | | | 25b. REGISTRAR'S SIGNATURE <u>Carroll S. Kraus</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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